



2014 Supplemental Budget

Operating & Capital Budget

PUBLIC HEALTH
ALWAYS WORKING FOR A SAFER AND
HEALTHIER WASHINGTON

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Capital Budget

Recommendation Summary

Agency: 303 - Department of Health

10:29:06AM

10/3/2013

Dollars in Thousands

Annual Average
FTEs

General
Fund State

Other Funds

Total Funds

2013-15 Current Biennium Total

Total Carry Forward Level

Percent Change from Current Biennium

M1 TC Nursing Center Resource Tech Corr

(1,008) (1,008)

Carry Forward plus Workload Changes

Percent Change from Current Biennium

(1,008) (1,008)

Total Maintenance Level

Percent Change from Current Biennium

(1,008) (1,008)

PL BR Behavioral Risk Factor Survey
 PL HW Childhood Obesity Prevention Proj
 PL LC Online Licensing
 PL LH Support of Local Public Health
 PL ME Marijuana Education
 PL PH Public Hlth Issues Mgmt System
 PL TQ Tobacco Quitline

0.9	871		871
	384		384
1.9		848	848
1.2	375		375
0.9	472		472
3.8	2,147		2,147
	663		663

Subtotal - Performance Level Changes

8.5 4,912 848 5,760

2013-15 Total Proposed Budget

8.5 4,912 (160) 4,752

Percent Change from Current Biennium

Recommendation Summary

Agency: 303

10:29:06AM

10/3/2013

Dollars in Thousands

Annual Average
FTEsGeneral
Fund State

Other Funds

Total Funds

MI TC Nursing Center Resource Tech Corr

The Department of Health, Nursing Care Quality Assurance Commission requests a technical correction in appropriation authority by reducing the Health Professions Account (02G) appropriation. Substitute House Bill 1343 was adopted during the 2013 session and the correct fund source related to that bill is the Nursing Resource Center Account (09L), which is a non-appropriated account.

PL BR Behavioral Risk Factor Survey

The Behavioral Risk Factor Surveillance System is a telephone survey about health behaviors and disease conditions in adults. The survey provides essential information to state and local government agencies that use the information to inform planning and priority-setting, target prevention resources, and evaluate programs to improve the health of Washingtonians. Due to the loss of tobacco prevention funds and other funding for the collecting and managing this data, the department now has less than half the resources needed to sustain this essential information tool.

PL HW Childhood Obesity Prevention Proj

The Department of Health requests General Fund-State to partner with the Office of Superintendent of Public Instruction and Department of Early Learning on a comprehensive childhood obesity prevention project. The project identifies opportunities work together using proven best practices, creates obesity prevention toolkits, and reports to the governor and legislature on strategic initiatives that target high-impact methods to prevent childhood obesity.

PL LC Online Licensing

The Department of Health is requesting FTE and appropriation authority to do research and planning for the design and development of the upcoming Online Licensing and Information Collection project. This project will be fully funded by fees collected from health care professions and facilities. Current operating revenue will support the additional operating expenses of this proposal. As a result, this proposal does not require any fee increases.

PL LH Support of Local Public Health

In order to maximize public health's impact on the overall health of all Washington communities, it is essential that the Department of Health and Local Health Jurisdictions work together as a cohesive system. This request is to provide tools and other support to assess local community health and develop local health improvement plans; align local planning into a state health improvement plan, and collaboratively develop performance measures and public health outcomes.

PL ME Marijuana Education

The Department of Health requests General Fund-State to start the creation, implementation, operation, and management of a marijuana education and public health program to inform school-age children and adults on the health and safety risks posed by marijuana. This work is required under Initiative Measure 502.

PL PH Public Hlth Issues Mgmt System

Recommendation Summary

Agency: 303

10:29:06AM

10/3/2013

Dollars in Thousands

Annual Average
FTEs

General
Fund State

Other Funds

Total Funds

Providers and laboratories are required by Washington state law to report cases of infectious and communicable diseases to the public health system, which is currently received by two data systems that are not technologically current, fail to meet the users' needs, and are at risk of being decommissioned if a replacement is not implemented within the next two years. These systems need to be replaced by a single reliable Public Health Issues Management System. Data collected and analyzed in a single system allows public health officials to respond rapidly to health emergencies like an outbreak of pandemic flu or hepatitis.

PL TO Tobacco Quitline

The Department of Health requests General Fund-State to provide tobacco cessation services to approximately 2,900 people who will remain underinsured and uninsured during and after the initial wave of Medicaid and Health Benefits Exchange enrollment. This public health investment recognizes that various financial hardship factors will prevent some of the state's currently 740,000 uninsured adults from securing insurance coverage under provisions of the Affordable Care Act.

State of Washington
Decision Package

FINAL

Agency: 303 Department of Health
Decision Package Code/Title: TC Nursing Surcharge Technical Corrections
Budget Period: 2013-15
Budget Level: M1-Inflation and Other Rate Changes

Recommendation Summary Text:

The Department of Health, Nursing Care Quality Assurance Commission requests a technical correction in appropriation authority by reducing the Health Professions Account (02G) appropriation. Substitute House Bill 1343 was adopted during the 2013 session and the correct fund source related to that bill is the Nursing Resource Center Account (09L), which is a non-appropriated account.

Fiscal Detail

Operating Expenditures		<u>FY 2014</u>	<u>FY 2015</u>	<u>Total</u>
02G-1	Health Professions Acct	(504,000)	(504,000)	(1,008,000)
				0
Total Cost		(504,000)	(504,000)	(1,008,000)

Package Description:

The department was given appropriation authority for the Nurses Surcharge proviso (1U0) in the Health Professions Account (02G). Although the fund source should have been the non-appropriated Nursing Resource Center Account (09L). The Expenditure Authorization Schedule for the department provides the correct amount for the Nursing Resource Center Account (09L). Because of the error, the proviso funding from the Health Professions Account was put in un-allotted in the departments initial allotment packet.

Agency Fiscal Contact: Steve Hodgson, 360-236-4990
Subject Matter Expert: Paula R. Meyer, 360-236-4713

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

No performance outcomes will change as a result of this technical correction.

Performance Measure Detail

Not applicable.

Is this DP essential to implement a strategy identified in the agency's strategic plan?

Not applicable.

Does this decision package provide essential support to one of the Governor's priorities?

Not applicable.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

Not applicable.

What are the other important connections or impacts related to this proposal?

Department of Health is submitting these technical corrections as agreed to by Office of Financial Management.

What alternatives were explored by the agency and why was this alternative chosen?

Not applicable.

What are the consequences of not funding this package?

Not applicable.

What is the relationship, if any, to the state capital budget?

Not applicable.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

None.

Expenditure and revenue calculations and assumptions

None.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

This is a one-time technical correction for the 2013-15 biennium.

<u>Object Detail</u>	<u>FY 2014</u>	<u>FY 2015</u>	<u>Total</u>
A Salaries and Wages			
B Employee Benefits			
C Personal Service Contracts			
E Goods and Services			
G Travel			
J Capital Outlays			
N Grants, Benefits & Client Service	(504,000)	(504,000)	
T Intra-Agency Reimbursements			
Total Objects	(504,000)	(504,000)	0

State of Washington
Decision Package

FINAL

Agency: 303 Department of Health
Decision Package Code/Title: HW Childhood Obesity Prevention Project
Budget Period: 2013-15
Budget Level: PL-Performance Level

Recommendation Summary Text:

The Department of Health requests General Fund-State to partner with the Office of Superintendent of Public Instruction and Department of Early Learning on a comprehensive childhood obesity prevention project. The project identifies opportunities work together using proven best practices, creates obesity prevention toolkits, and reports to the governor and legislature on strategic initiatives that target high-impact methods to prevent childhood obesity.

Fiscal Detail

Operating Expenditures		FY 2014	FY 2015	Total
001-1	General Fund- State	87,000	297,000	384,000
Total Cost		87,000	297,000	384,000

Package Description:

Promoting healthy starts and reducing the prevalence of obesity among children takes a coordinated effort. Other states have found opportunities for collaboration and using best practices to prevent chronic obesity – and it’s working. According to the Robert Wood Johnson Foundation, the states currently showing a decline in childhood obesity rates have made, “...broad, sweeping changes to make healthy foods available in schools and communities – and integrate physical activity into people’s daily lives.” The requested funding allows Department of Health and partner agencies to collaborate on proven high-impact focus areas to reduce childhood obesity. Specifically the funding pays for staff in the Department of Health, Office of Superintendent of Public Instruction, and Department of Early Learning to work on strategies that promote sweeping changes to the way state and local entities reduce childhood obesity in Washington.

There are more than 1.4 million children and youth in Washington according to the Office of Financial Management. Data shows that about 11 percent of 2-4 year olds enrolled in the Women, Infants, and Children (WIC) program are obese (2012) – and 10 percent of high school students are obese (2012). Children who are obese are significantly more likely to become obese adults according to the Journal of Adolescent Health. Obese children and adults have higher risk for heart disease, stroke, diabetes, and cancer. These chronic diseases pose a significant burden on Washington’s health care system and inflate public and private health care costs. The estimated annual medical cost for adult obesity in Washington is \$2.98 billion.

Chronic diseases including obesity are the leading causes of death in Washington. Childhood obesity is caused by factors such as parental health, infant feeding practices, unhealthy nutrition and physical activity choices by children and parents, and policies and environments that make it difficult for kids to eat healthy and be active. The Department of Health, Office of Superintendent of Public Instruction, and Department of Early Learning are well positioned to play key roles to significantly reduce childhood obesity. However, the state lacks a coordinated and comprehensive approach for addressing childhood obesity.

Investment in Obesity Reduction

Department of Health requests General Fund State dollars to implement a cross-agency project to significantly reduce childhood obesity with Office of Superintendent of Public Instruction and Department of Early Learning. Each of the following Childhood Obesity Prevention Project areas requires collaboration as well as policy and systems change strategies to reduce the prevalence of obesity in Washington:

1. **Women's health before and during pregnancy:** Women who are overweight or obese when a pregnancy begins are more likely to have an overweight or obese child. This is also true for women who gain too much weight during pregnancy. In 2011, about 25 percent of women were obese before pregnancy and about 31 percent gained too much weight during pregnancy.
2. **Breastfeeding promotion:** Breastfeeding can help to protect a child from becoming overweight or obese. The American Academy of Pediatrics recommends exclusive breastfeeding for six months. Only 20 percent of mothers in Washington report exclusively breastfeeding for six months.
3. **Healthy child care and early learning environments:** Nationally about 24 percent of children up to four years old are primarily cared for in a day care, preschool, or head start setting. About 430,000 infants and children were enrolled in licensed/unlicensed early learning environment in 2012 in Washington. According to the Women, Infants, and Children nutrition program enrollee data, about 11 percent of preschoolers were obese in 2012.
4. **Healthy school environments:** Children eat up to half of their daily calories at school and spend up to half of their waking hours there. About 10 percent of middle and high school students are obese. In October 2013, more than 1 million children were attending school.

The agencies have identified work products and high impact strategies as part of the Childhood Obesity Prevention Project:

1. Department of Health will measure progress toward goals in improving the health of mothers and infants and monitor the ongoing obesity prevention work using multiple data sets.
2. Department of Health will work with hospitals, clinics, worksites, and early learning facilities to develop and implement comprehensive breastfeeding policies and support for breastfeeding mothers.
3. In collaboration with stakeholders, Department of Early Learning will create a Childhood Obesity Prevention Toolkit for early learning professionals, including child care providers and early childhood education and assistance contractors. This will be available on Department of Early Learning's website.
4. Department of Early Learning and Department of Health will ensure childhood obesity prevention strategies are embedded in the Early Achievers Program, the state's voluntary Quality Rating and Improvement System described in RCW 43.215.100.
5. Department of Early Learning will use research and best practices to improve the performance standards of early care and education professionals. These standards will include, but are not limited to, nutrition education work for children in written curriculum plans, physical activities, and screen time education to parents.
6. Office of Superintendent of Public Instruction will collaborate with stakeholders to create a childhood obesity prevention toolkit for schools. It will include free and low-cost options for schools to use. The

toolkit will include contact information for public and private stakeholders that can provide technical assistance, resources, and staffing to schools during implementation of the toolkit.

7. Office of Superintendent of Public Instruction will produce materials to help school districts create obesity prevention curricula, policy, and environmental changes to improve obesity and education outcomes for children.
8. Office of Superintendent of Public Instruction will use childhood obesity prevention research and best practices when revising the state's health and fitness standards.
9. Department of Health, Office of Superintendent of Public Instruction, and Department of Early Learning will consider childhood obesity prevention research and best practices when revising rules concerning children's health outcomes.

In addition to these high impact strategies, Department of Health will coordinate creation of a plan for future cross-cutting strategies to prevent childhood obesity. The plan will serve as the springboard for comprehensive statewide action that includes:

1. Identifying other collaboration opportunities between Department of Health, Office of Superintendent of Public Instruction, and Department of Early Learning, along with recommended actions;
2. Identifying additional policy and budget recommendations including a range of actionable items for consideration by the legislature;
3. Additional action steps and outcomes to reduce childhood obesity, including a focus on reducing health disparities in specific population groups;
4. Costs and resources required to implement future activities; and
5. Identifying public-private partnership opportunities to leverage public resources and generate broader impact to promote children's health.

Department of Health will coordinate a report summarizing the results and recommendations of the Childhood Obesity Prevention Project including:

1. Impacts of childhood obesity on short and long term health outcomes, health care and other costs, academic achievement in early learning, and school settings.
2. Identification, description, and gap analysis of state and local government and community-based programs to prevent childhood obesity, including cross-agency efforts.
3. Assessment of feasibility, benefits, and challenges of strategies in four focus areas: Women's health before and during pregnancy; Breastfeeding promotion; Healthy child care and early learning environments; and Healthy school environments.

Ultimately the report and coordinated action plan will do several things to help reduce childhood obesity:

- **Provide staffing in each agency to focus on childhood obesity:** This will enable all three agencies to prioritize and ensure children have every opportunity to achieve a healthy weight while the agencies continue progressing on an already full list of priorities.
- **Provide direction for stakeholders to create synergy for statewide strategies:** Many statewide coalitions have developed strategies to address childhood obesity. This report and action plan will provide context and options for them to incorporate into their policy strategies for the future.
- **Increase effectiveness of policy and systems changes:** Each of the three state agencies has responsibilities related to creating healthy, safe places for kids. These responsibilities come with

competing priorities. Through this planning process, agencies can share barriers to and strengths of policy and systems options, and ultimately develop solutions that can work better for all.

- **Adopt strategies:** Partner agencies will be able to use the action plan to develop their strategic plans and take stronger positions in coalitions and partnerships.
- **Improve the health of environments children interact with on a regular basis, such as schools and early learning facilities:** Kids will be more likely to make healthier choices that ultimately lead to reductions in childhood obesity rates and more children with a healthy weight status.

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Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

Implementation of the activities proposed in this decision package will allow Department of Health to:

- Increase the percent of mothers who breastfeed their infants through six months of age.
- Increase the number of students engaging in physical activity at school.
- Increase the number of people with increased access to healthy food and beverages in institutional settings, early learning environments.
- Increase the number of people with better and easier access to physical activity in communities through Complete Streets, Safe Routes to Schools, and related built environment.

Performance Measure Detail

Activity: A002 Chronic Disease Prevention

Is this DP essential to implement a strategy identified in the agency's strategic plan?

This decision package supports the following 2012-16 Department of Health Strategic Plan goal and objective:

Goal 2: Policies and systems in Washington support a healthy start to life and ongoing wellness for all.

Objective 1: We promote health and reduce health disparities through policy change.

Strategy 1: Engage new partners to enact policy and systems changes that support tobacco-free living, active living, and healthy eating.

Does this decision package provide essential support to one of the Governor's priorities?

Yes. Washington will be more successful at childhood obesity prevention if agencies have the needed resources and strategic plan to support the work. Developing a coordinated, cross-agency plan for reducing childhood obesity is a major step toward building momentum and capacity for reducing childhood obesity statewide.

This decision package directly and indirectly supports Results Washington Goal 4 – Healthy and Safe Communities:

- Measure 1.2.Y-b: Increase percentage of 10th graders with healthy weight from 75 percent to 76 percent by 2016.
- Measure 1.2.A-a: Increase percentage of adults with healthy weight from 37 percent in 2011 to 38 percent by 2016.
- Measure 1.2.A-a.1: Increase percentage of persons with healthy weight by 2016 among Native Hawaiians/Other Pacific Islanders from 26 percent to 27 percent; American Indians/Alaska Natives from 22 percent to 23 percent; African Americans from 24 percent to 25 percent; Hispanics from 26 percent to 27 percent.

The work products outlined in this decision package also support point number 9 of *Governor Inslee's Building a Working Washington Health Care System: Make Washington a healthier state with a focus on childhood obesity*. <http://www.jayinslee.com/issues/healthcare>

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

Yes. It addresses childhood obesity, which is increasingly recognized as an issue that impacts health care costs and prevalence of chronic disease. This work supports the Priorities of Government – Statewide Results Area to *Improve the health of Washingtonians*. This work is specifically linked to the Improve Healthy Behaviors indicator – and the Obesity Rate Among Adults and Obesity Rate Among Youth measures.

What are the other important connections or impacts related to this proposal?

Department of Health, Department of Early Learning, and Office of Superintendent of Public Instruction engaged stakeholders in creating the agency request legislation leading to this decision package. Several stakeholders are working to improve childhood and adult obesity rates through policy and environmental change. The state YMCA recently received funds from Robert Wood Johnson Foundation to promote policy and environment change in state policy, communities, schools, and early learning. The Childhood Obesity Prevention Coalition and other stakeholders have been promoting policy and environmental change in early learning facilities for several years. The strategies in this decision package support the stakeholders' work.

What alternatives were explored by the agency and why was this alternative chosen?

Department of Health considered developing a policy platform and recommendations for the governor to consider. Department of Health decided to instead work with Department of Early Learning and Office of Superintendent of Public Instruction to ensure optimum coordination and broad impact. It is important to engage both Department of Early Learning and Office of Superintendent of Public Instruction in problem-solving to ensure sustainable approaches to preventing childhood obesity and reducing obesity rates.

What are the consequences of not funding this package?

The lack of a systematic approach will prevent the state from having broad and lasting impact on childhood obesity.

What is the relationship, if any, to the state capital budget?

None.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

Department of Health is proposing agency request legislation that also involves Office of Superintendent of Public Instruction and Department of Early Learning. There is no all-encompassing law addressing systemic childhood obesity prevention in Washington. These new sections would fold into existing statutes (RCW Chapter 70) and would be the start to a comprehensive statewide approach to address childhood obesity. Prospective policy alternatives may require additional rulemaking and legislation.

Expenditure and revenue calculations and assumptions

Revenue:

None.

Expenditures:

In the last quarter fiscal year (FY) 2014 and continuing into FY 2015 the requested funding will support the following:

- Department of Health will require 1.0 FTE of a Health Services Consultant 3 (HSC3), and .50 FTE of an Epidemiologist 2 (Epi 2). Total cost is \$186,000. The consultant will be responsible for facilitating this collective effort, coordinating the report generation, and gathering expertise on women's health, breastfeeding promotion, and healthy eating/active living strategies as needed. The Epi 2 will assist with literature and best practices review and data collection. The Epi 2 will also analyze and synthesize data from various sources such as Healthy Youth Survey, Pregnancy Risk Assessment Monitoring System, and Women, Infants and Children Program.

Department of Health will use interagency agreements (personal service contracts) to pass funding through to Department of Early Learning and Office of Superintendent of Public Instruction.

- Department of Early Learning will require 1.0 FTE of a Program Specialist 5 to serve as an obesity prevention coordinator within the agency. Total cost is \$98,000. The specialist will be the liaison between Department of Early Learning and Department of Health; coordinate with Thrive by Five, Coalition on Safety and Health in Early Learning, Child Care Aware, and other relevant partners; serve as a subject matter expert on early childhood development; and provide expertise on the best prevention strategies to implement in child care and early learning environments.
- Office of Superintendent of Public Instruction would require 1.0 FTE of a Health Services Consultant 4 to serve as an obesity prevention coordinator within the agency. Total cost is \$100,000. The consultant would be the liaison between Office of Superintendent of Public Instruction and Department of Health; coordinate with Educational Service Districts and School Nutrition Association, School Nurses of

Washington, and other relevant partners; serve as a subject matter expert on the relationship between academic achievement and health; and provide expertise on the best prevention strategies to implement in schools.

Total estimated expenditures in FY 2014 are \$87,000 and FY 2015 \$297,000. The Department of Health will use existing FTE by redirecting current staff with proper expertise to this priority short term effort.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

This initial request is for one-time project funding. Per the proposed legislation, partner agencies will submit recommendations to prevent childhood obesity in a report to the governor and appropriate legislative committees identifying specific strategies, feasibility, and costs associated with each of the focus areas identified above. Upon reviewing the recommendations the governor and/or legislature may consider policy options and appropriate funding levels needed to reduce the prevalence of childhood obesity in Washington.

For federal grants: Does this request require a maintenance of effort or state match?

No.

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

No.

Object Detail		FY 2014	FY 2015	Total
A	Salaries and Wages	24,000	99,000	123,000
B	Employee Benefits	7,000	30,000	37,000
C	Personal Service Contracts	50,000	148,000	198,000
E	Goods and Services	5,000	18,000	23,000
G	Travel	0		0
J	Capital Outlays	1,000		1,000
T	Intra-Agency Reimbursements	0	2,000	2,000
	Agency Indirects			0
Total Objects		87,000	297,000	384,000

Agency: 303 Department of Health
Decision Package Code/Title: BR Behavioral Risk Factor Survey
Budget Period: 2013-15
Budget Level: PL-Performance Level

Recommendation Summary Text:

The Behavioral Risk Factor Surveillance System is a telephone survey about health behaviors and disease conditions in adults. The survey provides essential information to state and local government agencies that use the information to inform planning and priority-setting, target prevention resources, and evaluate programs to improve the health of Washingtonians. Due to the loss of tobacco prevention funds and other funding for the collecting and managing this data, the department now has less than half the resources needed to sustain this essential information tool.

Fiscal Detail

Operating Expenditures		FY 2014	FY 2015	Total
001-1	General Fund-State		871,000	871,000
Total Cost		0	871,000	871,000

Package Description:

The Department of Health requests \$871,000 in general fund state monies to continue performing Behavioral Risk Factor Surveillance System (BRFSS) surveys which inform priority-setting strategies by state and local agencies utilizing limited funding to improve the health of Washington residents.

BRFSS is a telephone survey the department has conducted since 1987 concerning health behaviors and disease conditions in Washington residents aged 18 years and over. The surveys capture data on many health topics, including whether people smoke, exercise, have health insurance, get screened for certain cancers, have heart disease, diabetes, or other diseases. The surveys provide essential information to state and local agencies that use the data to inform planning and priority-setting, target prevention resources and evaluate programs to improve resident's health in Washington while utilizing limited resources.

The BRFSS survey effectively informs health policy decisions because it collects enough information to measure health issues at the local level and among different population groups. For instance, BRFSS data from 2009-2010 show that in Cowlitz County, 37 percent of adults are obese, while 21 percent of adults are obese in King County. BRFSS data from 2008-2010 show that the smoking rate for Native Americans (31%) is more than twice as high as the smoking rate for the general population in Washington (15%). With limited resources to address critical public health issues, the department must make targeted investments, focusing prevention dollars on areas of the state and segments of the populations where those funds will have the greatest impact.

For example:

- When the department received a large federal grant for prevention activities, the department used BRFSS data to assess community and behavioral risks for chronic disease in Washington. With this information, the department was able to target the new funding to counties with the greatest burden of chronic disease risk and the greatest opportunity for prevention. These eleven targeted counties then used local BRFSS data to target their funding and intensive interventions toward people at highest risk.

- The department's Tobacco Prevention and Control Program used BRFSS data to measure state progress in preventing tobacco use. While the department saw the smoking rate decline among the general population, further analysis of the BRFSS data showed that smoking rates were remaining steady among people with low incomes. The program used this information to redirect resources on activities to help low income smokers quit.

Until 2010, the department had sufficient funding to conduct the surveys, relying on a blend of funding sources including Tobacco Prevention funds, a BRFSS grant from the Centers for Disease Control and Prevention and contributions from agency programs and other agencies that use the data. Since 2010, the department has lost more than half of these resources.

The department must collect 12,500 surveys each year in order to measure and compare health behaviors and disease conditions across Washington at a cost of approximately \$1.3 million per year. The department estimates approximately \$445,550 available in fiscal year 2015 from all funding sources to conduct the surveys and maintain the data. This could be significantly lower depending on federal grant amounts. The department requests \$871,000 in general fund state monies to close this gap.

Julie Miracle, Operations Manager, 360-236-4230
Christie Spice, subject matter expert, 360-236-4307

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

To obtain BRFSS results at the local level and for different segments of the population, we need a minimum of 12,500 surveys each year. With this level of BRFSS data collection:

- State agencies, including the Department of Health, the Office of Financial Management, the Department of Labor and Industries, and the Department of Social and Health Services will have BRFSS data needed to plan programs, target services, and evaluate the effectiveness of their work.
- Communities will have data describing their specific health needs, which will allow them to plan local health improvement strategies and apply for funding to support the work.
- Organizations serving people of color and the poor will have data on health disparities they can use to develop plans to address the specific health needs of these groups.
- Policy makers will have reliable, specific data on the health of Washingtonians to guide their decision making.

BRFSS data will be an essential data source to measure several of the leading indicators of the Governor's Results Washington initiative.

Performance Measure Detail

While there is not a direct agency performance measure associated with the BRFSS, the data collected from it is used to inform other agency performance measures.

Is this DP essential to implement a strategy identified in the agency's strategic plan?

BRFSS supplies data that are crucial to measuring the success of several strategies outlined in the department's Strategic Plan for 2012-2016:

- Goal 2 – Policies and systems in Washington support a healthy start to life and ongoing wellness for all. (BRFSS data will allow the department to measure progress preventing tobacco use, physical inactivity, poor nutrition, and other chronic disease risk factors.)
- Goal 3 – Everyone in Washington has improved access to safe, quality, and affordable health care. (BRFSS data will allow the department to track whether Washingtonians have health insurance and a regular access to medical care.)

BRFSS data will also be essential to monitoring the state's progress on reforming the governmental public health system. The department and local health jurisdictions (LHJs) have developed an Agenda for Change Action Plan that establishes system-wide priorities for public health improvement. Echoing the agency's Strategic Plan, two of these priorities focus on chronic disease prevention and health care access. BRFSS data, at the state and local levels, will tell the department and LHJs how they are doing and where they need to focus their efforts.

BRFSS data form the basis for much of *The Health of Washington State*, the department's report on the health of the state's population. The department also publishes data for a set of local public health indicators, used routinely by LHJs to set priorities, plan actions, and measure results. BRFSS data are necessary for more than half of these health indicators.

Does this decision package provide essential support to one of the Governor's priorities?

Yes, this decision package links to Governor Inslee's Goal 4: Healthy and Safe Communities. BRFSS data will be an essential data source to measure several of the leading indicators of the Governor's Results Washington initiative.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

BRFSS data measure two of the indicators in the Priorities of Government process:

- Indicator 1: Improved Healthy Behaviors. Two of the measures (adult obesity and tobacco use) are calculated using BRFSS data.
- Indicator 2: Improved Life Expectancy. One of the measures, years of healthy life at age 20, is calculated using a combination of BRFSS and death data.

Conducting at least 12,500 surveys a year is essential to continue to track these priorities at the state and local level.

What are the other important connections or impacts related to this proposal?

Many state and local government agencies, non-profit organizations, and researchers in Washington use BRFSS data to plan, evaluate or monitor their work. The following are examples of just a few organizations that rely on BRFSS data. The examples of data use described below are possible only when the department conducts more than 12,500 surveys a year:

- The department used BRFSS data to determine that people with adequate health insurance were not receiving appropriate colorectal cancer screening. As a result, the department applied for and received federal funding to promote colorectal cancer screen to healthcare providers and the public. The department currently uses BRFSS data to make sure that these prevention activities continue to increase cancer screening rates.
- The Department of Social and Health Services (DSHS) uses BRFSS data to measure and plan services for alcohol and substance abuse among adults. Previously, DSHS used BRFSS data to identify information needs among caregivers for the elderly and disabled. Based on this data, DSHS expanded their caregiver program to include a more comprehensive set of services.
- The Health Care Authority used BRFSS data to compare health and wellness information for state employees to the rest of the state population. This comparison drove decisions for targeting worksite wellness interventions.
- The Department of Labor and Industries uses BRFSS data to determine if health conditions and behaviors differ for people working in various occupations and industries, and to assess the percent of workers with some work-related illnesses and disabilities.
- The Office of Financial Management (OFM) uses BRFSS data to meet their legislative requirement to develop a statewide health resource strategy. OFM uses BRFSS data to identify geographic variations in health risk factors, population characteristics, and use of preventive services.
- The Governor's Interagency Council on Health Disparities uses BRFSS data to describe differences in health status by race and ethnicity. The council uses this information to set state priorities for eliminating health disparities and to develop strategies described in the State Policy Action Plan to Eliminate Health Disparities.
- LHJs in Washington routinely use BRFSS data to prioritize prevention efforts, write grants, and increase awareness of health issues in the community. For example, when Clark County Public Health identified a rapid rise in local obesity rates using BRFSS data, they partnered with community organizations to apply for funding to address this issue. When funded, they used BRFSS data to develop strategies to address obesity in worksites, health systems, schools, and communities. As a result, they were able to fund eight worksites in Clark County to provide healthy choices in vending machines and ban tobacco use on campus.
- Researchers at the University of Washington and other universities use BRFSS data to learn about factors that affect Washington residents' health, and to evaluate which policies and prevention practices most effectively improve population health.
- The Gates Foundation used BRFSS data to inform their Family Homelessness charitable giving program in Washington.

What alternatives were explored by the agency and why was this alternative chosen?

The department has pursued all federal funding opportunities available, but due to federal budget cuts we have not been successful. Another option explored was to increase the charge programs and other state agencies pay for adding questions to the survey. However, while the department has increased the charges for BRFSS questions in recent years, we won't be able to raise them high enough to close the gap since the programs and agencies that pay for questions have also experienced state and federal budget reductions.

What are the consequences of not funding this package?

The main consequence of not funding this package is a reduction in the number of BRFSS surveys the department conducts. The Department requests \$871,000 in funding to supplement the \$445,550 of available funding for the surveys. At the current funding level, the department would only be able to conduct approximately 4,284 out of the necessary 12,500 surveys. If BRFSS conducts fewer than the 12,500 needed surveys, the department will lose the ability to examine important health issues in different area of the state and different segments of the population. This will prevent state agencies and others from using BRFSS data to target their resources or measure the impact they are having. Local governments will be forced to target dwindling resources without the benefit of community data to help discern the most effective and efficient use of these resources. State agencies will lose the ability to use BRFSS data to examine the effect they are having on improving health and risk behaviors for racial and ethnicity minorities and people in lower socio-economic groups.

What is the relationship, if any, to the state capital budget?

None

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

None

Expenditure and revenue calculations and assumptions

Revenue:

N/A

Expenditures:

The BRFSS costs a total of \$1.3 million per year to conduct 12,500 surveys. The department projects about \$445,550 of federal and other funding available on-going. The department requests general fund state through this decision package to cover the remaining \$871,000.

This large, statewide survey is managed on 2.25 FTE. The department requests \$158,000 to partially meet this staffing need of 1.25 FTE, with the assumption that the other 1.0 FTE will continue to be supported by federal funds. The department does not request additional FTE. This decision package will continue support for the following FTEs assigned to BRFSS:

- 0.50 Health Services Consultant 4 (survey planning and implementation; grant development; contract monitoring; stakeholder input and communication)
- 0.50 Epidemiologist 2 (data management and analysis, technical assistance on data use)
- 0.05 Epidemiologist 3 (technical supervision and oversight for Epidemiologist 2)
- 0.20 WMS 2 (program and budget management)

Estimated expenditures for printing are \$5,000. The department contracts with a survey company to conduct the telephone interviews. The cost is about \$95 per completed cell phone interview and \$70 per completed land line interview. The department requests funds to collect an additional 8,821 surveys: 6,079 land line and 2,742 cell phone. The total purchased services will be \$686,020:

6,079 landline interviews * \$70 per interview = \$425,530

2,742 cell phone interviews * \$95 per cell phone interview = \$260,490

In addition, estimated ongoing expenditures starting in FY 2015 include costs for salary, benefits, and related staff costs for 0.1 FTE Health Services Consultant 1 and 0.3 FTE Fiscal Analyst 2 totaling \$21,980.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

This request is for \$871,000 per year of ongoing funding. The BRFSS is a continuous telephone survey that collects data 12 months a year, every year. The public health and governmental needs for the data and the costs of maintaining this survey are expected to be ongoing in future biennia.

For federal grants: Does this request require maintenance of effort or state match?

N/A

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

None, this funding request does not fulfill a federal grant's maintenance of effort or match requirement.

Object Detail	FY 2014	FY 2015	Total
A Salaries and Wages		121,000	121,000
B Employee Benefits		37,000	37,000
C Personal Service Contracts			
E Goods and Services		711,000	711,000
G Travel			
J Capital Outlays			
T Intra-Agency Reimbursements		2,000	2,000
Total Objects	0	871,000	871,000

Agency: 303 Department of Health
 Decision Package Code/Title: ME Marijuana Education
 Budget Period: 2014 Supplemental
 Budget Level: PL-Performance Level

Recommendation Summary Text:

The Department of Health requests General Fund-State to start the creation, implementation, operation, and management of a marijuana education and public health program to inform school-age children and adults on the health and safety risks posed by marijuana. This work is required under Initiative Measure 502.

Fiscal Detail

Operating Expenditures		FY 2014	FY 2015	Total
001-1	General Fund - Basic Account - State		472,000	472,000
				0
Total Cost		0	472,000	472,000
Staffing		FY 2014	FY 2015	Annual Avg
	FTEs		1.7	0.9

Package Description:

The passage of Initiative Measure 502 legalizes, taxes, and regulates recreational marijuana retail sales and consumption. The initiative earmarks 10 percent of marijuana-related revenue to the Department of Health for the creation, implementation, operation, and management of a marijuana education and public health program. Since the codification of I-502 and creation of the Dedicated Marijuana Account, no tax or fee revenue has been collected, so no legislative appropriation or revenue distributions have occurred. Funding this request allows the department to start the planning that leads to the implementation of program expectations outlined in I-502:

- Public health information phone line that provides referrals to substance abuse treatment providers.
- Grants program for community based organizations to prevent marijuana use by youth.
- Media-based education campaign that provides scientifically correct information on the health and safety risks posed by marijuana.

The Liquor Control Board expects licensed marijuana stores to be operational by spring 2014. As the state rapidly moves toward the start of retail sales of marijuana – and the substance become more readily available to adults and youth – the planning and implementation of a marijuana education and public health program enables the Department of Health and its partners to educate people about potential health and social consequences of marijuana consumption. Currently, no marijuana info line exists in Washington and evidence-based educational media information is scarce around the country. Many stakeholders, including those who voted in favor of I-502, expect statewide prevention measures that offset beliefs that legalization for recreational use means that marijuana is a harmless or low risk substance. To date, planning around educational programming under I-502 has not begun because dedicated funding is not available. Therefore, the state’s public health messaging and fulfillment of its marijuana education responsibilities lag behind the drive toward retail sales. Although a portion of the requested funding will go toward immediate education and awareness work that align public health

messaging with retail availability and the consumption realities of marijuana legalization, much of the staff work will involve setting up Request for Information (RFI) and Request for Proposals (RFPs) to secure contracts and/or vendor relationships so when adequate revenue is distributed in subsequent fiscal years (FY), the state is ready to launch a public health referral info line targeted at substance abuse; and a media-based education campaign to inform the public about health and safety risks posed by marijuana. State health is required to implement a grant program for community based organizations to prevent marijuana use by youth. The preparation for this will be done in FY 2015 and the implementation will occur in FY 2016.

Launching the Marijuana Education Program will require 1.70 FTEs to set up program infrastructure – and funding for print and web-based media. We do not anticipate being able to fully execute the comprehensive program requirements in the first year with only this supplemental funding. Staffing for this first year will allow state health to create an appropriate model for implementing the required ‘marijuana info line’ and completing a competitive process to select a contractor to operate that phone line. It will also provide an opportunity to research and identify the best method to implement a comprehensive public education campaign. Department of Health will use information from previous successful campaigns as applicable – such as tobacco, alcohol, prescription drug abuse, traffic safety, and healthy community initiatives. While each of these campaigns have been effective, none can be used to address marijuana use as this issue presents unique circumstances and our state is the first in the nation to attempt a shift from criminalization to legalization. Most public health professionals and residents understand that smoking in any form may be harmful, but marijuana consumption comes in many forms that may not be as distinguishable – edibles, vaporizers, oils, tinctures, and cooking ingredients, for example. Initiating public health interventions that mitigate potential negative impacts of marijuana is uncharted territory for the Department of Health and its partners.

Agency Fiscal Contact: Diamatris Winston, 360-236-3940

Agency Subject Matter Expert: Paul Davis, 360-236-3642

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

Department of Health expects the work described to produce the following results:

- Offer a counterbalance to offset youth attitudes about marijuana – and the acceptance of legalized marijuana – to reduce adult and particularly youth consumption.
- Align public health messaging with retail availability and the consumption realities of marijuana legalization.
- Proactive prevention. Gradually reverse or alter the sentiment among an increasing number of youth who believe that occasional marijuana use poses little or no risk. Data from the Healthy Youth Survey over the past decade show trends of marijuana use, acceptance and tolerance rates among youth.
- Fulfillment of public health responsibilities and prevention objectives as outlined in I-502 and codified into law.
- Planning during FY 2015 enables the health department to create marijuana education and public health programming that is ready to effectively and efficiently use the 10 percent of Dedicated Marijuana Account earmarked for marijuana education.
- Department of Health will be ready to launch and implement a grant program for community based organizations to prevent marijuana use by youth once regular distributions from the Dedicated Marijuana Account are available.

Performance measure detail

Activity: Code Title A002 – Chronic Disease Prevention

Is this DP essential to implement a strategy identified in the agency's strategic plan?

This decision package is the result of a voter initiative that identifies new roles and responsibilities that are not part of the existing strategic plan. These new public health leadership roles are being incorporated by the agency and its partners as requirements of I-502 are implemented – and statewide needs and opportunities are realized.

Does this decision package provide essential support to one of the Governor's priorities?

Results Washington does not have a general measure related to substance abuse or one specifically for marijuana. Results Washington Council Goal 4 – Healthy and Safe Communities has measures for cigarette smoking and chemical dependency. At some point, a measure related to general substance abuse may fall under Results Washington Council Goal 4.

Legalizing marijuana is a prominent issue around the country, capturing the attention of the US Department of Justice (DOJ). The DOJ recently decided to let Washington and Colorado essentially become pilot projects for marijuana legalization. The federal agency plans to track each state's ability to manage public health and social consequences and prevent distribution to minors. That may lead to this issue becoming a governor's priority.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

Yes. The state's ability to provide accurate information and referral to treatment for marijuana use is likely to have significant statewide impact and become a priority. Local entities are already looking to state health for leadership, guidance, and evidence-based educational materials that are understandable by diverse audiences. There is substantial federal, state, and media interest in the way Washington handles marijuana legalization, so our efforts will be critiqued and potentially replicated by other states and countries.

What are the other important connections or impacts related to this proposal?

Distribution of revenue from the marijuana industry will lag behind retail sales by at least one quarter – and although a revenue forecast for the Dedicated Marijuana Account is not available, distributions are expected to be low and insignificant for the first few quarters. The state health department is part of the secondary group of revenue recipients, so it may be even longer before dedicated revenue is available for marijuana education. This General Fund-State request allows us to initiate the creation, implementation, and management of a statewide marijuana education program closer to the start of retail sales to mitigate public health and safety consequences.

Washington is one of only two states to legalize recreational use of marijuana. In addition to the timely and full implementation of a measure passed by nearly 56 percent of the voters during 2012, the state is being closely watched by the federal government and other states. Deferring resources and not moving ahead with prevention strategies during the early stages of marijuana legalization may result in implementation problems, such as delaying distribution of important prevention messages. And it may lead to the perception of failure and

mismanagement. Consequences at the state and national level could include federal intervention such as injunctions or other legal actions.

The Department of Health has experience implementing and managing statewide educational programs that warn against tobacco use and promote cessation using both state and federal funding. The agency cannot use existing federal funds to conduct marijuana education programs because these funds have categorical restrictions – and marijuana is still considered a level I controlled substance at the federal level. Only state funding can be used for marijuana-related activities. Providing statewide leadership and educational resources specific to marijuana use will require dedicated funding.

What alternatives were explored by the agency and why was this alternative chosen?

This alternative was selected because adequate revenue collections and distributions will likely occur after marijuana is widely available at state licensed stores. It will take Department of Health and its partners a considerable amount of time and effort to implement the education components of I-502. Waiting for adequate distributions from the Dedicated Marijuana Account will put the state farther behind in terms of full implementation – and full implementation under voter-approved I-502 and current law requires the state to educate people about the health and safety risks of marijuana.

Alternatives:

- The state could wait until adequate tax and fee revenue distributions become available through the Dedicated Marijuana Account.
- The state could reprioritize a small portion of the state's Liquor Revolving Funds for the purpose of implementing the I-502 required marijuana education program – with funding made available to Department of Health through a budget proviso or interagency agreement.

What are the consequences of not funding this package?

The longer the state waits to provide post-legalization marijuana education the harder it becomes to educate the public about the health, social, and safety consequences of marijuana. As a result, the belief that legalization for the purpose of decriminalization means that marijuana is harmless or low risk substance becomes the social normal among impressionable school-age youth and young adults. Failure to provide a counterbalancing message before people start marijuana use can result in higher rates of marijuana acceptance and use among teens – and higher rates of abuse and addiction among adults.

The Surgeon General's report on tobacco use among youth and young adult concludes that mass media campaigns, comprehensive community and statewide programs reduce initiation of smoking, as do school-based programs. Below are examples of why prevention campaigns are important and effective at deterring drug use:

- In 2012, about one in five sophomores and more than a quarter of high school seniors said that they used marijuana in the past 30 days. While these prevalence rates have been relatively stable over the past few years, there has been a steady decline in perception of harm from marijuana. Perception of harm has consistently been a predictor of future use trends for substances.
<http://www.samhsa.gov/data/2k13/nsduh099a/sr099a-risk-perception-trends.htm>
- Immediately after the tobacco master settlement, strong media campaigns were effective at influencing attitudes and behaviors of youth towards tobacco. Washington's comprehensive tobacco prevention and control campaign resulted in a 50 percent reduction in cigarette smoking prevalence. There is conclusive

scientific evidence that media and community-based campaigns are effective.
<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446163/pdf/10705855.pdf>

What is the relationship, if any, to the state capital budget?

None.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

The initiative calls for Department of Health and Department of Social and Health Services (DSHS) to implement rules needed to carry out their marijuana activities by December of 2013. So far, no rules are needed to implement agency responsibilities related to educational programs. Contracts with local health entities and other community based organizations will occur when regular distributions from the Dedicated Marijuana Account become available.

Expenditure and revenue calculations and assumptions

Revenue:

None.

Expenditures:

The requested \$472,000 General Fund-State allows Department of Health to start the planning that leads to the implementation of the program expectations as outlined in I-502. The agency anticipates the need to fund 1.70 existing FTEs for first year planning and implementation work – staffing includes:

- 0.2 FTE of Health Services Consultant 4 to manage the marijuana education program and lead interagency consultation and development of appropriate educational materials.
- 1.0 FTE of Health Services Consultant 3 to coordinate development of educational outreach materials for school-age youth; manage contracts for the development and distribution of educational materials; and development of bid processes and contracts for the Marijuana Hotline and media campaigns.
- 0.5 FTE of Epidemiologist 2 to provide consultation on science-based educational materials and recommendations based on analysis of scientific literature and existing survey data of youth and young adults regarding marijuana use.

These existing FTEs are partially or wholly funded by federal grants and state marijuana activities cannot be charged to federal grants.

The cost of printed and web-based educational media including updates to the existing Alcohol and Drug Abuse Institute web site is estimated at \$253,000. Updating the Alcohol and Drug Abuse Institute website with accurate information and providing print and electronic educational materials to students in grades 6-12 will maximize educational outreach during the first year and provide schools relevant information to include in existing health or substance abuse curriculum. In the past, Educational Service Districts were used to develop and distribute tobacco prevention educational material. This model could be used for marijuana education as well. The following is a cost breakdown for printed and web-based educational media for the first year:

- There are about 450,000 youth between the ages of 13 and 17 in the state based on population data collected by the Office of Financial Management. Printing educational materials for this target audience will be \$67,500. This does not include the cost of production or distribution, which is estimated at \$35,500.
- The current cost of the Department of Health's secondhand smoke website and outreach program is \$150,000. We anticipate needing a similar amount to create strategic communication plans and web-based information for the first start-up year.

Total costs in FY 2015 will be 1.70 FTE and \$472,000.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

The need for General Fund-State support is expected to be one-time as Dedicated Marijuana Account revenues should be available for distribution in following fiscal years.

For federal grants: Does this request require a maintenance of effort or state match?

None.

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

No.

Object Detail		FY 2014	FY 2015	Total
A	Salaries and Wages		140,000	140,000
B	Employee Benefits		44,000	44,000
C	Personal Service Contracts		253,000	253,000
E	Goods and Services		26,000	26,000
G	Travel			0
J	Capital Outlays		6,000	6,000
T	Intra-Agency Reimbursements		3,000	3,000
	Total Objects		472,000	472,000

State of Washington
Decision Package

FINAL

Agency: 303 Department of Health
Decision Package Code/Title: LH Support of Local Public Health
Budget Period: 2013-15
Budget Level: PL-Performance Level

Recommendation Summary Text:

In order to maximize public health's impact on the overall health of all Washington communities, it is essential that the Department of Health and Local Health Jurisdictions work together as a cohesive system. This request is to provide tools and other support to assess local community health and develop local health improvement plans; align local planning into a state health improvement plan, and collaboratively develop performance measures and public health outcomes.

Fiscal Detail

Operating Expenditures			FY 2014	FY 2015	Total
	001-1	General Fund-State	0	375,000	375,000
Total Cost			0	375,000	375,000
Staffing			FY 2014	FY 2015	Annual Avg
	FTEs			2.0	1.0
Revenue			FY 2014	FY 2015	Total
	Fund	Source			
			0	0	0
Total Revenue			0	0	0

Package Description:

Funding to support creating and maintaining a cohesive statewide public health system was eliminated when the legislature combined local public health funding into a single block grant. Promoting healthy, prevention-based behaviors and providing a safe environment is the core of the public health's work. In addition to increasing the quality and number of healthy years of the population, these measures have been demonstrated to be cost-effective strategies that save money that would otherwise be spent later on health care services.

Public health services in Washington are provided through a decentralized system involving the Department of Health (DOH) and 35 different local health jurisdictions that receive local, state and federal support.

RCW 43.70.51 requires a statewide plan for improvement, including standards for public health protection and strategies for improving public health programs, including identifying performance measures to measure progress. This work is especially important in an era of health care reform and implementation of the Affordable Care Act. State and federal health care reform laws require hospitals and public health agencies to coordinate community health assessments and health improvement plans.

The Public Health Improvement Partnership is directed by the legislature (RCW 43.70.520 and 580) to guide and strengthen the public health system in Washington State. In 2012, the Partnership adopted an Agenda for Change Action Plan to guide the transformation of our public health network in addressing the continuously changing economic and health care landscape. This action plan commits us to the following three approaches:

- Strategically prioritize our work to focus on preventing communicable disease and other health threats, fostering healthy communities and environments, and partnering with the health care system to improve the health of our communities
- Ensure every resident in Washington can access a foundational set of public health services, no matter where they live
- Develop a performance management and accountability mechanism which uses activities and services, indicators and standards to measure the performance of the public health system in our state

With Foundational Public Health Services and strategic priorities now defined in the Agenda for Change, we're ready to develop and implement a statewide health improvement plan. To make these strategies a reality, we will focus on workforce development, modify business practices for maximum impact, and identify long-term, sustainable financing for programs and services in a coordinated effort.

The future work of public health agencies must include retraining their workforce so they have the skills and competencies to meet today's challenges. Recruitment, selection, and retention strategies must be implemented to address skills gaps in health equity, policy change, social media, and communications.

The Agenda for Change also calls on Washington's public health network to transform its business practices and reprioritize its work by:

- Working with policymakers to set and prioritize specific health outcomes, and establish ways to measure them.
- Streamlining performance and accountability measures on public health actions that lead to the achievement of the prioritized health outcomes.
- Committing fully to quality improvement by striving to meet state and national public health standards.
- Critically evaluating and reprioritizing our limited resources, and better defining roles and responsibilities among the overlapping government authorities and jurisdictions.
- Modernizing and sustaining capabilities to collect, analyze, and share information, that policy makers, health agencies, and the public can use to make Washington a healthier place to live.

One of the key approaches the Public Health Improvement Partnership will take on the next two years is focus on a set of strategic priorities to enhance our ability to work together with essential partners, resulting in the most impact for the investment and effort. These priorities will move the public health system toward increased consistency in business practices and will fulfill public expectations for consistent services from government across the state.

DOH proposes to provide tools and other support to assess local community health and develop local health improvement plans; align local health planning into a state health improvement plan, collaboratively developing performance measures and public health outcomes; support quality improvement across state through technical assistance, workforce development, and support for national accreditation.

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

A resilient and effective public health network, that is coordinated and responsive.

Performance Measure Detail

Activity: A008 Strengthening the Public Health System

Is this DP essential to implement a strategy identified in the agency's strategic plan?

This package contributes to the following elements of our strategic plan:

Goal 1: People in Washington are protected from acute communicable diseases and other health threats
Objective 3: Our partnerships and activities increase immunization rates and reduce school exemption rates

Goal 2: Policies and system in Washington support a healthy start to life and ongoing wellness for all
Objective 1: We promote health and reduce health disparities through policy change

Goal 3: Everyone in Washington has improved access to safe, quality, and affordable health care.
Objective 2: Public health and prevention practices are incorporated into the health care delivery systems.

Does this decision package provide essential support to one of the Governor's priorities?

Yes, this package supports Goal 4 Healthy and Safe Communities.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

This package contributes to several leading indicators related to the goal topic Healthy People under Goal 4 of Results Washington. We believe a coordinated statewide public health system would rate very high under the Priorities of Government.

What are the other important connections or impacts related to this proposal?

Washington State's Public Health Performance Management Centers for Excellence (MCE) offer technical assistance, resources, and training in performance management. We emphasize public health standards and accreditation, especially through community health assessments, community health improvement plans, strategic plans, quality improvement projects and plans. Our goal is to develop sustainable local performance management capacity and to improve health outcomes.

MCE began in 2010 under the National Public Health Improvement Initiative, funded by the U.S. Centers for Disease Control and Prevention. Our three locations support local health jurisdictions, Tribal agencies, and the state Department of Health. The three locations are Spokane Regional Health District, Tacoma-Pierce County Health District and the state Department of Health (DOH).

MCE provides tailored technical assistance, resources, promising practices, training and support with the goal of developing sustainable local performance management capacity to improve public health outcomes. This request will provide resources needed for DOH to adequately support MCE.

Additionally, community health assessment (CHA) should be part of an ongoing broader community health improvement process. A community health improvement process uses CHA data to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement, which are often outlined in the form of a community health improvement plan (CHIP). A community health improvement process looks outside of the performance of an individual organization serving a specific segment of a community to the way in which the activities of many organizations contribute to community health improvement.

The Public Health Accreditation Board's (PHAB's) national, voluntary, public health department accreditation program, requires a current (completed within the last 5 years) CHA and CHIP as two of the three prerequisites for accreditation of state and local public health agencies.

Charitable hospitals also are required by the federal Patient Protection and Affordable Care Act (ACA) to conduct community health needs assessments.

Local health jurisdictions are in the process of conducting and implementing community health assessment and improvement plans. Currently:

- 51% of Washington's local health jurisdictions have a current CHA
- 20% of Washington's local health jurisdictions have a current CHIP

During the 2012 session, the Washington state legislature passed ESHB 2341 that requires nonprofit hospitals to make community health needs assessments and community benefits implementation strategies widely available to the public. RCW 70.41.470

Hospitals in our state are also in the process of conducting community health needs assessments and plan. This request provides resources needed to provide assistance and coordination for CHA's and CHIP's statewide

What alternatives were explored by the agency and why was this alternative chosen?

Since the elimination of funding to support creating and maintaining a statewide public health system, we've explored alternative funding from federal funders, and private funders, such as the Robert Wood Johnson foundation. No federal funding for this specific purpose currently exists. Private funders sometimes offer resources for systems work such as is being proposed; however, these resources are often intended to seed development and not sustain ongoing work. We believe we are well-developed in understanding our system needs, and have a primary need for ongoing sustainable funding.

What are the consequences of not funding this package?

The consequences of not funding this request would be a fragmented statewide public health system. Given the current system needs, especially in light of health care reform, we will not be able to sustain the degree of coordination between local community health assessment and planning and state health improvement planning to appropriately position the public health system to bring value to the new health care delivery environment. Also, absent dedicated funding, we will not be able to sustain advances we've made in performance management and quality improvement, and our workforce will continue to struggle to develop the knowledge and skills necessary to deliver a public health system our communities deserve.

What is the relationship, if any, to the state capital budget?

None

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

None

Expenditure and revenue calculations and assumptions

Revenue:

N/A

Expenditures:

Support for local community health assessment and planning:

\$90,000 per year to maintain the Community Health Assessment Tool (CHAT). The CHAT provides secure web-based access to a repository containing a variety of data collections gathered and maintained by DOH. The CHAT tool permits the continuation of established periodic assessments by Local Health Jurisdictions and other healthcare professionals in DOH while enlarging the opportunities for accessing and understanding these data.

\$114,000 for 1.0 FTE and associated costs for a Health Services Consultant 4 to develop and coordinate State Health Improvement Planning and serve as state and local accreditation coordinator, assisting local health jurisdictions in seeking an acquiring national public health accreditation.

Support for performance measurement and quality improvement:

\$40,000 per year, contracted to WSALPHO, to develop and implement performance measures and reporting as required by the Local PH Support Block Grant

\$25,000 per year to provide matching grants to LHJs to pursue national public accreditation.

Support for workforce development:

\$106,000 for 1.0 FTE and associated costs for a Health Services Consultant 3 for the DOH MCE augmenting existing work to improve local public health quality improvement efforts and other training and support and \$25,000 annually to pay for the enrollment of the local public health workforce in Washington's central E-Learning system.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

All costs and functions will be ongoing.

For federal grants: Does this request require maintenance of effort or state match?

N/A

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

N/A

Object Detail	FY 2014	FY 2015	Total
A Salaries and Wages		147,000	147,000
B Employee Benefits		45,000	45,000
C Personal Service Contracts		0	0
E Goods and Services		115,000	115,000
G Travel			0
N Grants		65,000	65,000
T Intra-Agency Reimbursements		3,000	3,000
Total Objects	0	375,000	375,000

State of Washington
Decision Package

FINAL

Agency: 303 Department of Health
 Decision Package Code/Title: LC Online Licensing
 Budget Period: 2013-15
 Budget Level: PL-Performance Level

Recommendation Summary Text:

The Department of Health is requesting FTE and appropriation authority to do research and planning for the design and development of the upcoming Online Licensing and Information Collection project. This project will be fully funded by fees collected from health care professions and facilities. Current operating revenue will support the additional operating expenses of this proposal. As a result, this proposal does not require any fee increases.

Fiscal Detail

Operating Expenditures			FY 2014	FY 2015	Total
	02G-1	Health Professions Ac	848,000	0	848,000
Total Cost			848,000	0	848,000
Staffing			FY 2014	FY 2015	Annual Avg
	FTEs		3.8		1.9
Revenue			FY 2014	FY 2015	Total
	Fund	Source			
	02G-1	0299 Other Licenses/Permits			
Total Revenue			0	0	0

Package Description:

Department of Health's (DOH) Division of Health Systems Quality Assurance (HSQA) is responsible for licensing and regulating health care professions and facilities. Currently, HSQA licenses approximately 7,000 facilities and close to 400,000 providers in 83 professions. The volume of new provider applications and the number of professions regulated by the department continues to grow. Timely processing of provider license applications and renewals is an important component of patient safety because it improves access to care. In addition, information consistency and accuracy will improve because edits embedded in an online system require entry of complete responses.

In February 2008, DOH implemented a vendor system to support core licensing and disciplinary activities for health care providers, facilities, and services. In the 2011-13 biennial budget, the department requested and received FTEs and appropriation authority to implement online access and payment functionality for health care provider licensing renewals for all professions and new applications for eight professions. That project was completed on schedule on June 30, 2013. In the 2013-15 biennial budget, the department requested an additional 8.1 biennial FTEs and \$2,577,000 in appropriation authority beginning in Fiscal Year (FY) 2014 to continue to implement online access and payment functionality for new license applications for the remaining health care professions and new license applications and renewals for at least five regulated facility types. The request also included automating the processing of surcharges and implementing functionality to collect demographic information for health care providers. The department received 8.2 annual FTEs and \$1,693,000 in FY 2015 for the Online Licensing and Information Collection project. The department is requesting an

additional 4.1 annual FTEs and \$843,000 appropriation authority in FY 2014 to complete research and planning for the design and development of this project.

Initially the department expected to use functionality included in the vendor system to implement online processing of applications for new licenses. After implementing online license renewals during the 2011-13 biennium the department was able to more fully assess the capacity of the online components in the vendor system, and gain important knowledge about customer expectations and practices. It is now clear that the vendor system is not able to accommodate the variety and complexity of the statutory requirements for Washington state health care professions and facilities license applications. The department explored working with other state agencies to use existing online systems and talked with the vendor about modifying its system to accommodate the Washington State requirements. DOH determined that developing its own online components that link to the core vendor system would be the most efficient and least risky approach.

Given the complexity of the Online Licensing and Information Collection project and its importance to patient safety and health care system planning, it is essential that the department begin project planning in FY 2014. The department is also proposing to develop the requirements and research options for the collection of demographic information. Thorough pre-planning will reduce project risk and allow the benefits of the Online Licensing and Information Collection project to be realized sooner. At the end of this pre-planning effort the department would have a detailed project plan for the Online Licensing and Information Collection project, an operational online system prototype for at least one health care profession license type, general requirements for all health care profession license types, a detailed plan and requirements for implementing the collection of health care provider demographic information and detailed requirements for the use of automated processing of surcharges on individual health care licensees.

Agency Fiscal Contact: Steve Hodgson, 360-236-4990.

Subject Matter Expert: Dan Francis, 360-236-4425.

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

Beginning project planning for the Online Licensing and Information Collection project in FY 2014 will reduce project risk and allow the benefits of the Online Licensing and Information Collection project to be realized sooner. Those benefits include:

1. Health care providers and facility administrators will be able to renew or apply for licenses, check the status of applications and licenses, and pay online twenty-four hours per day, seven days per week. The turn-around time for application processing will be reduced because providers and facility administrators will be able to enter information and pay online. The number of checks returned for insufficient funds (NSF) will be reduced because online payments will be validated prior to acceptance by the online system. Refunds will be reduced because the online system will require submission of the correct amounts for each type of transaction. Information consistency and accuracy will improve because edits in the online system will require entry of complete responses.
2. Health care providers will be able to enter demographic information online when they renew their license. Accurate health care workforce information will improve access to health care and reduce health disparities by: 1) assisting policy makers in developing targeted solutions to address workforce shortages; 2) identifying workforce needs culturally and geographically to meet future health care demands; 3) assessing training and educational needs for the health care workforce; 4) helping the health care workforce mirror the populations they serve; and 5) promoting diversity in the field.

3. The process for applying and processing surcharges on individual health care licenses will be fully automated.

Performance Measure Detail

Activity: A015 Patient and Consumer Safety

Is this DP essential to implement a strategy identified in the agency's strategic plan?

Goal 3: Everyone in Washington has improved access to safe, quality, and affordable health care.

Objective 1: Our regulatory system supports the delivery of quality and efficient patient care.

Strategy 1: Remove barriers and streamline regulatory processes.

Goal 4: Business practices and processes provide the greatest value to the public and ensure accountability.

Objective 1: The health information and services we provide meet the needs of our customers and are delivered in efficient and effective ways.

Strategy 1: Expand our on-line business capabilities.

Strategy 3: Develop a plan to guide how we collect, manage, analyze and present data that informs public health decisions.

The Online Licensing and Information Collection project supported by this proposal will implement a system that will reduce health care provider license processing time and increase information accuracy. Patient safety is enhanced when providers are able to practice sooner and accurate information about the workforce is available to conduct meaningful health care system planning.

Does this decision package provide essential support to one of the Governor's priorities?

Yes. This supports Results Washington Goal 4 Healthy and Safe Communities and Goal 5 Efficient, Effective and Accountable Government.

Goal 4 Healthy and Safe Communities – the Online Licensing and Information Collection project supported by this proposal will enhance patient safety for the health care system in Washington State. Ultimately that project will implement twenty-four hour per day online access, seven days per week, for providers to submit license applications, renewals and payments. In addition, that project will implement the capability to collect demographic information on the health care workforce which will improve access to health care and reduce health disparities by supporting effective health care system planning, and assisting policy makers in developing targeted solutions to address workforce shortages.

Goal 5 Efficient, Effective and Accountable Government – the Governor has asked departments to look for more cost effective, efficient ways to do business and implement LEAN principles to reduce waste and make business processes more efficient. The current licensing process is paper based and very labor intensive. Expanding the online service delivery model will allow the department to eliminate the waste and inefficiency associated with paper processing. If the department continues to do business in the same way, the number of staff needed will continue to grow. Automating and redesigning businesses processes to align with LEAN principles is expected to slow the need for additional staff while supporting good customer service as the demand for service increases.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

Yes. This supports the Governor's Health Care priority. With increasing evidence of provider shortages, timely processing of provider license applications and renewal is an important component of patient safety because it improves access to care. The capability to collect demographic information on the health care workforce will also improve access to health care and reduce health disparities by supporting effective health care system planning and assisting policy makers in developing targeted solutions to address workforce shortages.

What are the other important connections or impacts related to this proposal?

For several years, the providers, through their boards, commissions and professional associations, have requested the ability to pay by credit card and the efficiency of online licensing. Completion of this project demonstrates a responsive state government.

What alternatives were explored by the agency and why was this alternative chosen?

Initially the department expected to use functionality included in the vendor system to implement online processing of applications for new licenses. After implementing online license renewals during the 2011-13 biennium the department was able to more fully assess the capacity of the online components in the vendor system, and gain important knowledge about customer expectations and practices. It is now clear that the vendor system is not able to accommodate the variety and complexity of the statutory requirements for Washington state health care professions and facilities license applications.

The department considered partnering with another agency to deliver online services. The approach was not feasible due to the complexity of the statutory requirements related to health care provider licensing and the necessary linkage to the department's core system.

The department also considered not moving forward with expanding online services. This approach would have a number of negative impacts on the agency's ability to improve service to customers. The current licensing process is paper based and very labor intensive. Timely processing of provider license and facility applications is an important component of patient safety because it improves access to care.

What are the consequences of not funding this package?

If the department is not funded for this effort, it will not be able to begin research and planning for the Online Licensing and Information Collection project for which it received funding in the 2013-15 biennial budget. This will further delay the recognition of the benefits and increase the risks for that project.

What is the relationship, if any, to the state capital budget?

None.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

None.

Expenditure and revenue calculations and assumptions

Revenue:

There is sufficient revenue to support this request.

Expenditures:

Staff necessary includes 0.8 FTE Program Managers (WMS02), to plan and manage the project keeping it within budget and on schedule. The research and planning team will consist of 0.8 FTE Information Technology Specialist (ITS) 4 and 2.2 FTE ITS 5. Total staffing and related costs, including indirect costs are \$442,000. Additional computer hardware is estimated to be \$10,000 and a personal service contract of \$396,000 for developing online components that link to our current system.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

All costs are one-time.

For federal grants: Does this request require maintenance of effort or state match?

None.

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

Object Detail		FY 2014	FY 2015	Total
A	Salaries and Wages	231,000	0	231,000
B	Employee Benefits	72,000	0	72,000
C	Personal Service Contracts	396,000	0	396,000
E	Goods and Services	134,000	0	134,000
G	Travel	0	0	0
J	Capital Outlays	10,000	0	10,000
T	Intra-Agency Reimbursements	5,000	0	5,000
Total Objects		848,000	0	848,000

State of Washington
Decision Package

FINAL

Agency: **303 Department of Health**
 Decision Package Code/Title: **PH Public Health Issues Management System**
 Budget Period: **2013-15**
 Budget Level: **PL-Performance Level**

Recommendation Summary Text:

Providers and laboratories are required by Washington state law to report cases of infectious and communicable diseases to the public health system, which is currently received by two data systems that are not technologically current, fail to meet the users' needs, and are at risk of being decommissioned if a replacement is not implemented within the next two years. These systems need to be replaced by a single reliable Public Health Issues Management System. Data collected and analyzed in a single system allows public health officials to respond rapidly to health emergencies like an outbreak of pandemic flu or hepatitis.

Fiscal Detail

001	General Fund State	0	2,147,000	2,147,000
Total Cost		0	2,147,000	2,147,000
Staffing		FY 2014	FY 2015	Annual Avg
FTEs			7.5	3.8

Package Description:

The Department of Health requests \$2,147,000 in general fund state monies in fiscal year 2015 to purchase a new commercial-off-the-shelf (COTS) system to replace the current Public Health Issue Management Systems which receive, manage and disseminate data related to public health outbreaks that require rapid response.

Providers and laboratories are required by Washington state law (WAC 246-101) to report cases of infectious and communicable diseases (notifiable conditions) to the public health system which is currently received by two systems, the Public Health Issue Management System (PHIMS) and Public Health Issue Management System for Sexually Transmitted Diseases (PHIMS-STD). Both of these systems have been built and maintained with federal funds. Federal program officers have communicated to the department that federal funding is no longer available for on-going maintenance for the systems and that replacement and sustainability of our infectious and communicable disease systems are entirely the state's responsibility. After years of federal cuts, and subsequent loss of maintenance team positions, the systems are outdated, not technologically current, fail to meet the users' needs, and are at risk of being decommissioned if a replacement is not implemented in the near term.

Improving our health care system requires simultaneous pursuit of three aims: improving the experience of care, improving the health of populations, and reducing per capita costs of health care. This approach is referred to as the "Triple Aim". Public health plays a particularly important role in pursuit of the Triple Aim in terms of using data to describe the health of communities by: (1) collecting, connecting, compiling, and analyzing data to inform changes at both population-based and individual health levels and (2) performing community health assessments to identify health needs to develop health improvement plans. The Affordable Care Act, with its emphasis on the development of Health Information Technology, is creating expanded opportunities to collect

information about health status, health care delivery, and health care costs, and this data has the potential to make analysis of population health richer and more valuable for measuring progress towards Triple Aim goals.

Problems to be solved and opportunities to be taken advantage of include the following:

- The department relies on receiving the infectious/communicable diseases and chronic health conditions data from local health jurisdictions (LHJs). However, not all LHJs use PHIMS/PHIMS-STD to report and/or manage data for all conditions because the systems do not meet their business needs and resort to developing their own internal systems. Multiple reporting systems creates difficulties in maintaining and upgrading systems and information across all partners, resulting in increased staff time, cost and delay in real-time information.
- More health data exists in electronic formats, particularly since health care providers have been incentivized to put their health records into electronic formats through the Affordable Care Act. PHIMS/PHIMS-STD does not have the interfaces necessary to accept data in the form of electronic case reports or electronic laboratory reports. At this time, data needs to be manually entered into the systems or manipulated electronically, resulting in increased staff time, cost, and delay in real-time information.
- The systems are not easily adaptable to new diseases and takes significant resources and time, both internally and externally, to upgrade. This delay in real time information impacts the ability to capture new conditions in a timely manner preventing state and local public health from containing the disastrous effects of a new disease while it spreads.
- Public health could benefit tremendously by the department exchanging information with other Washington public health agencies (Health Care Authority, Department of Social and Health Services) that are currently developing health data repositories. Benefits would include the exchange of data for the purposes of reporting, tracking, and management of infectious/communicable diseases, in addition to obtaining new data that will allow for analysis of population level health that include social determinants of health and health care costs. PHIMS/PHIMS-STD does not have the capability of connecting to these systems.

A number of COTS systems have been developed to manage public health data and are being used by others across the country. One of several COTS systems could be acquired that would resolve many, if not all, of the problems listed above. Acquiring such a system would have the added advantage of allowing Washington to join and work together with other states using a similar COTS systems facing similar challenges and opportunities. The department will work in collaboration with local health jurisdictions to evaluate and choose the COTS system that best meets public health business needs across the public health system.

Agency Fiscal Contact: Julie Miracle, 360-236-4230

Agency Subject Matter Expert: Wayne Turnberg, 206-418-5559

Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

The agency expects to see improvements in the following measures:

1. Decrease in the time elapsed from clinical identification of a case until reporting to the public health system achieved through:

- Ability to accept electronic data (case reports, laboratory reports), resulting in elimination of the need to manually enter case information or extensively manipulate electronic data to enter into the system.
- Ability in the Health Information Exchange to recognize and capture cases of disease for transmission to the public health system.
- Electronic import of data originating in neighboring states/other jurisdictions.
- Ability to capture data faster and act quicker will result in reduction in spread of disease and faster linkage to care for people with disease.

2. Increase in the amount of information public health will receive, resulting in more complete case reports as well as additional capacities to do better, more varied analysis which could include:

- Better geographic analysis of disease.
- Impact of social determinants on disease acquisition and spread.
- Co-morbidities (for example, between physical health conditions and behavioral health issues).

Ability to do these types of analysis will contribute to understanding what work needs to be done to impact the health of populations, assure that individuals have access to quality care, and identify how to reduce health care costs.

3. Efficiencies gained:

- Consolidation of more than two systems into one (two at the state health department, multiple others at the local level) will reduce costs since maintenance and upgrades will not need to be done on multiple systems.
- This will eliminate the need for manual entry of data.

With improved systems that would allow for faster identification of diseases, cost savings would also be realized to the health care system by averting spread of disease and getting ill and exposed people to care more quickly.

Performance Measure Detail

This decision package is specific to the 2012-2016 Department of Health performance measures under:

Goal 1: People in Washington are protected from acute communicable diseases and other health threats

Objective 1: Our surveillance systems support early detection and swift response.

Strategy 3: Modernize our integrated infectious disease data collection system

Performance Measure 1: Percent of new system built

Performance Measure 2: Percent of new system built and percent of local health using the new electronic data collection system.

Is this DP essential to implement a strategy identified in the agency's strategic plan?

This DP is integral to the agency's strategic plan. Under Goal #1, "People in Washington are protected from acute communicable diseases and other health threats," there is an objective that states, "Our surveillance systems support early detection and swift response." Under this objective, there are two strategies that are directly impacted by the outcome of this decision package. They are:

- Strategy 1: Enhance our surveillance systems with data available through the Health Information Exchange.
- Strategy 3: Modernize our integrated infectious disease data collection system.

With the current systems, we will not be able to achieve the first strategy in a meaningful way and in a reasonable time frame. The second strategy is the subject of this DP.

Does this decision package provide essential support to one of the Governor's priorities?

Yes, this decision package links to Governor Inslee's Goal 4: Healthy and Safe Communities.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

Yes, the ability of public health systems to capture health data from populations across the state in a timely way makes key contributions to statewide results. The return on investment of a modernized public health data system could be realized in a very short period of time, such as responding to an outbreak of a virulent infectious disease, or in the longer term, by getting people with chronic infectious diseases to care as soon as possible so they don't develop the more severe (and expensive to treat) consequences of diseases.

The notifiable conditions information system acquired with this decision package would rank very high in the Priorities of Government process because it would have a positive impact on all four strategies that the state employs to improve the health of Washingtonians:

- 1) It would help '*Identify and mitigate risk factors*' by providing timely data on diseases and the demographic and socioeconomic factors associated with disease;
- 2) It would '*Mitigate environmental hazards*' by addressing exposure to communicable diseases, exposure to hazardous materials, such as lead, and it would include disease reporting for conditions associated with unsafe food and water;
- 3) It would help '*Provide access to appropriate health care*' by decreasing the time it takes to identify diseases and link people to care; and
- 4) It would '*Increase healthy behaviors*' by providing timely data associated with unhealthy sexual behavior.

What are the other important connections or impacts related to this proposal?

Potentially, all of the stakeholders working on achieving the Triple Aim are stakeholders impacted by the ability of public health to do this work.

The information system replacement proposed in this decision package enables important connections with other information systems, both within the agency and externally. The new system will enable interoperability with electronic laboratory reporting, both through the currently implemented mechanisms as well as the upcoming Health Information Exchange, as well as some types of case reporting and additional information such as that contained in Washington's vaccine registry.

Over the past two years, health care facilities and providers have spent considerable time and resources developing their capacity to capture, store and transfer electronic medical records. The facilities and providers will soon expect the department to accept those data and minimize their burden associated with reporting diseases of public health concern. The system proposed in this package will enable the department to meet those expectations and reduce their workload associated with meeting their regulatory obligations.

What alternatives were explored by the agency and why was this alternative chosen?

The department studied the upgrade and consolidation of PHIMS from either of its two current systems in conjunction with exploring the feasibility of acquiring a commercial system. Three key considerations argued against adapting and upgrading current systems:

- Both PHIMS systems are old systems and would require virtually complete reprogramming to bring them up to levels of modern functionality.
- A redevelopment of existing systems to meet contemporary standards would require at least twice the time as identification, qualification, acquisition, and implementation of a new system when the risk of continuing the current PHIMS system is already high.
- Maintenance of a new, upgraded system would represent a greater strain on DOH resources than receiving the same maintenance through a commercial package. Internal development of a new system would carry the risk that one or more component would take much longer to create or perform less successfully than the verifiable performance of existing functions of commercial systems. Thus, the risk of internal development would be concentrated in the early phases of the project to an unacceptable degree.

Given these facts, the benefits of acquisition outweighed the benefits of redevelopment. Doing nothing also poses an unacceptable risk to the agency.

What are the consequences of not funding this package?

If this package is not funded, public health will continue to rely on using multiple problematic systems and will lose opportunities to take advantage of current and evolving health information streams.

Specific consequences of not funding this package include:

- The data systems that support public health will continue to be disjointed, creating increased costs for maintenance and upgrades of multiple systems. LHJs utilizing their own systems will need to continue to maintain them at a time of diminished resources.
- We will not be able to take advantage of data coming through the Health Information Exchange or being collected in data repositories by other health agencies.

- Federal agencies are awarding resources to states that are able to take advantage of data from the evolving health information environment. If Washington is unable to do so, we will not be competitive for funding.
- Healthcare facilities and providers will react unfavorably if they have to continue meeting their disease reporting regulatory obligations in time-consuming and costly ways that does not take advantage of their significant investments in new health information technology.

What is the relationship, if any, to the state capital budget?

None.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

No changes required.

Expenditure and revenue calculations and assumptions

Revenue:

N/A

Expenditures:

There will be one-time costs in FY 2015 for 2.5 FTE ITS5 to plan, manage and execute the project and lead the preparation of the Request for Quotes and Qualifications (RFQQ) documentation and accompanying procurement tasks for the COTS system. Also to work with customers and stakeholders statewide to identify their business requirements, complete a comprehensive set of system requirement documents, develop product evaluation procedures, lead the evaluation and scoring of potential off-the-shelf products against system requirements, and ensure that the system is developed according to the business requirements. This position will also set up and configure system hardware, install the purchased software, modify software to meet business and IT requirements. There will be 0.1 FTE ITS6 to participate in project planning, provide for IT resource allocation, and lead communications and coordination across-divisions, the executive sponsor(s), and DOH senior management. There will be 0.1 FTE ITS4 to serve as a testing resource throughout the development phase. There will be 0.2 FTE Epidemiologist 3 to participate in project planning, requirements definition, formatting and migration of data. There will be 2.7 FTEs Epidemiologist 2 to participate in project planning, requirements definition, formatting and migration of data. Total salary and benefit costs in FY 2015 are \$447,415.

The COTS software product is estimated at a one-time cost of \$1,300,000, which includes the software, applicable modules, user licenses, support for data migrations, and enterprise-level software upgrades for the first year. The estimated costs were calculated from quotes obtained by three of the leading software vendors.

Additional equipment costs in FY 2015 include \$16,000 for two Microsoft SQL Server database software licenses and \$21,000 for two servers and related equipment. These expenses will be incurred every five years to maintain agency replacement schedules.

Total costs in FY 2015 will be 5.6 FTE and \$2,147,000.

In FY 2016, there will be one-time costs for 2.6 FTE ITS5 for deployment of the system, troubleshoot, test, and perform computer programming to correct system issues/bugs. There will be 0.1 FTE ITS4 to support the development of user training and support plans. There will be 0.1 FTE ITS3 to lead the development of user communication, training, and customer support plans including training materials, perform system account management activities, participate in user training, and provide phone and email technical support to users. There will be 0.1 FTE Epidemiologist 3 for testing, 1.1 FTE Epidemiologist 2 for testing, and support for the development of user communication, training, and customer support plans including training materials, and deployment of the system. Total salary and benefit costs in FY 2016 are \$326,476.

There will also be an ongoing maintenance contract for software maintenance and support estimated at \$241,000 per year beginning in FY 2016. This covers user license renewals and enterprise-level software patches or bugs fixed by the vendor. It does not cover enhancements or system modifications.

Total costs in FY 2016 will be 4.1 FTE and \$870,000

Starting in FY 2017, 1.1 FTE ITS5, 0.1 FTE Epidemiologist 2, and 0.1 FTE ITS 3 will be required to provide ongoing maintenance and support for the system. Staff will perform upgrades to hardware and software, apply routine software patches, database management, continue to troubleshoot, test, and perform computer programming to correct system issues/bugs, solicit requirements, program, test, and deploy software enhancements, and provide technical support for users. There will also be an ongoing maintenance contract for software maintenance and support estimated at \$241,000 per year. Ongoing cost total 1.3 FTE and \$473,000.

Maintenance of existing PHIMS needs to continue until the new COTS system is implemented. Existing PHIMS requires regular IT resources to be operational. After the new system is implemented, the old system will be decommissioned and all resources transferred to provide maintenance and support for the new system.

Currently 1.9 FTEs support the maintenance, operations, and enhancements for both systems with federal grants providing the current funding. This funding is supplied by the Public Health Emergency Preparedness and Response (PHEPR) grant within the department, although this award is becoming increasingly limited at the Federal level due to budget cuts. Since funding of this project falls lower on the priorities for the PHEPR, we anticipate funding being eliminated for this activity in the next two years.

In the future state we are seeking to transfer 1.3 FTEs to General Funds State funding. The 1.3 FTEs will provide the maintenance and operations for the systems. The remaining 0.6 FTE will temporarily remain on federal funding, phasing out the federal grant based financial support, we expect to gain efficiency by combining the two systems and therefore be able to transition the 1.9 FTE of support to 1.3 FTE of support once the COTS solution is completely implemented and the old systems decommissioned. The additional ongoing costs are to pay the vendor to maintain and support the software and annual licensing fees.

The table below shows our current cost versus ongoing costs:

Category	Estimated Current Costs	*Estimated Ongoing Costs	Difference
FTE	1.9	1.3	(0.60)
Salary/Benefits	196,382	132,772	(63,610)
Goods/Services	20,921	14,315	(6,606)
COTS Maintenance Contract	0	241,000	241,000
Total Direct	217,303	388,087	170,784
Indirect	47,372	84,603	37,231
Total	264,675	472,690	208,015

*Does not include costs of \$37,000 for SQL Licenses and Servers and Hardware Replacement (5 year cycle)

In addition, estimated expenditures also include costs for salary, benefits, and related staff costs for 0.7 FTE Health Services Consultant 1 and 1.2 FTE Fiscal Analyst 2 in FY 2015; and 0.7 FTE and 1.3 FTE respectively in FY 2016. These ongoing administrative costs will decrease to 0.4 and 0.7 each year starting in FY 2017.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Costs listed for FY 2015 and FY 2016 will be one-time.

Starting in FY 2017, ongoing maintenance costs will be 1.3 FTE and \$473,000 each year.

For federal grants: Does this request require maintenance of effort or state match?

N/A

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

Object Detail	FY 2014	FY 2015	Total
A Salaries and Wages		534,000	534,000
B Employee Benefits		166,000	166,000
C Personal Service Contracts			
E Goods and Services		83,000	83,000
G Travel			
J Capital Outlays		1,355,000	1,355,000
T Intra-Agency Reimbursements		9,000	9,000
Total Objects	0	2,147,000	2,147,000

State of Washington
Decision Package

FINAL

Agency: 303 Department of Health
Decision Package Code/Title: TQ Tobacco Cessation Services
Budget Period: 2014 Supplemental
Budget Level: PL-Performance Level

Recommendation Summary Text:

The Department of Health requests General Fund-State to provide tobacco cessation services to approximately 2,900 people who will remain underinsured and uninsured during and after the initial wave of Medicaid and Health Benefits Exchange enrollment. This public health investment recognizes that various financial hardship factors will prevent some of the state's currently 740,000 uninsured adults from securing insurance coverage under provisions of the Affordable Care Act.

Fiscal Detail

Operating Expenditures		FY 2014	FY 2015	Total
001-1	General Fund -Basic Account State		663,000	663,000
Total Cost			663,000	663,000

Package Description:

State funding for the Quitline ended at the close of fiscal year (FY) 2013. According to the Centers for Disease Control and Prevention (CDC), Washington State is the only state without a state supported Quitline. This funding request will make Quitline services available to people who remain underinsured and uninsured during and after the initial wave of Medicaid and Health Benefits Exchange enrollment starting in October 2014. Demand for Quitline services remains high among the uninsured, underinsured and insured – this trend is expected to continue.

Quitlines have been researched and proven to be effective, at least doubling the chance of a person successfully quitting. CDC's Best Practices Guide research indicates a 38 percent success rate for Quitline callers after six months. Washington's Quitline has reported similar success with seven month follow up calls to Quitline users showing that 29 percent had not used tobacco in the past seven days. People who quit without help have about a 7 percent chance of being successful according to research published by Shu-Hong Zhu (PHD) in the American Journal of Preventive Medicine. <http://www.sciencedirect.com/science/article/pii/S0749379700001240>

With Affordable Care Act (ACA) enrollment starting in October 2013, the Department of Health (DOH) anticipates that many callers will be covered through Medicaid expansion or through the Health Benefits Exchange. However, state and national studies suggest that it will take time and effort through statewide outreach and enrollment campaigns before the estimated 740,000 uninsured adults in Washington are enrolled on a health plan. Furthermore, state and national studies suggest that there will still be people who are unable to purchase insurance due to financial hardship. Insurance gap impacts will also be realized by people who have grandfathered coverage under existing insurance plans that are not required to provide cessation services, as well as people moving between insurance coverage. DOH also expects instances where people with Medicaid will become ineligible as their incomes increase. Others will have gaps between open enrollment periods.

State Quitline – Present and Future

In FY 2013 there were 4,137 people without insurance or Medicaid coverage that accessed the tobacco Quitline. DOH anticipates about 70 percent of those people will remain underinsured and uninsured during and after the initial wave of Medicaid and Health Benefits Exchange enrollment starting in October 2014. This estimate is

based on data from the *Congressional Budget Office's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*. The remaining 2,896 callers would not have access to cessation services – and would continue to drive up the cost of healthcare for all Washingtonians. The estimated FY 2015 volume of 2,896 (unique callers) represents 70 percent of the total state funded calls in FY 2013. Call volume, frequency and request for nicotine replacement therapy (NRT) are the primary cost drivers. In FY 2013 just over 71 percent of Quitline callers made multiple calls – and requested NRT 89 percent of the time.

When Quitline funding was suspended in FY 2012, the Quitline experienced a wait list of 7,000 callers. So to stretch limited federal resources and operate without GF-State funding in FY 2014, Quitline service for the uninsured is limited to a single call (use) for up to 4,000 unique callers. To provide access to as many unique callers as possible, DOH has instructed the contractor to limit access to one single call (use) per unique caller without the benefit of evidence based practices such as access to multiple calls, and offering gum or patches to help them quit. These limiting factors may reduce Washington's Quitline success rate – and the associated benefits to public health outcomes and cost avoidance. In FY 2013, the Quitline received 25,201 calls of which 4,137 were from uninsured callers that were covered by the state funded Quitline contract. The remaining 21,064 calls were covered by Medicaid; private health insurance; contracts through employers, etc. The demand for Quitline services remains high. Reports from the National Association of Quitlines indicate that Washington State continues to have heavy use of our Quitline because so many people are accessing it through insurance plans, employer contracts with the Quitline, and the Medicaid fee-for-service benefit.

The requested funding will support Quitline services delivered through the contractor who also serves the state's Medicaid population as well as many private insurance plans. The level of service and intensity provided depends on the type of coverage carried by each caller, assuming the caller has coverage. Callers with health insurance plans that contract with the existing Quitline vendor, including Medicaid fee-for-service, or employer-purchased coverage of the Quitline are triaged at intake and not charged against the state Quitline contract. Callers with health plan benefits that do not pay for services from the Quitline vendor are transferred to their health plan provider. This funding request only targets uninsured callers, and can be aligned with prospective policy alternatives such as requiring health plans under the Exchange to cover cessation services for insured and uninsured tobacco users.

Quitline services are available to any adult in Washington State if they lack insurance coverage for tobacco cessation for the following reasons:

- No health insurance
- Medicare lacking any insurance benefit for cessation
- Indian Health Service
- Pregnant women
- Insured, but lack benefits that cover tobacco cessation services

There are two levels of benefits for people using Quitline services under the current vendor contract:

1. Single Call Benefit: 29 percent of the Quitline callers only request a single call. The single call benefit includes:
 - The initial call
 - Four weeks of nicotine replacement therapy when appropriate, this includes either the gum or patches
 - The quit kit containing self-help materials
2. Comprehensive Multiple Call Benefit: 71 percent of Quitline callers utilize up to five calls, and may request a four week supply of nicotine therapy gum or patches. The comprehensive benefit includes:
 - The initial intake call
 - Up to four proactive follow-up counseling calls

- Four weeks of nicotine replacement therapy when appropriate; this includes either gum or patches
- The quit kit containing self-help materials

Prior to the elimination of General Fund-State support for the Quitline, funding for the Cessation Coordinator position was split between General Fund-State and the CDC. Access to CDC grant funding beyond FY 2014 is unknown, so full General Fund-State support is being requested for FY 2015. This funding request includes existing staff capacity equivalent to 1.0 FTE for the coordination of Quitline activities with other cessation intervention efforts in the state. In FY 2015, the existing Cessation Coordinator will continue to educate healthcare providers on how to screen and refer patients to cessation services; and continue to collaborate and assist in Health Benefits Exchange efforts to ensure that health plan coverage of tobacco cessation services is adequate. As a subject matter expert, the Cessation Coordinator has successfully worked with the Health Care Authority to ensure existing Medicaid recipients receive Quitline coverage. Future efforts will be aimed at working with managed care plans and other health plans offered through the Health Benefits Exchange.

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Narrative Justification and Impact Statement:

What specific performance outcomes does the agency expect?

Access to Quitline services has reduced usage of tobacco products in Washington State based on CDC best practices analysis. Quitlines are effective in the delivery of cessation services. All states have state supported Quitlines that continue to experience high call volumes and high success rates. National/State statics indicate that Quitline success rates are much higher than for people trying to quit without Quitline services. Washington's Quitline research shows seven month abstinence rates of 29 percent. CDC's Tobacco Best Practice Guide indicates that other states such as Colorado exceed Washington's abstinence rate – data indicates Colorado has a 6 month abstinence rate of 38 percent. Both of these studies reviewed programs using the multiple call method that also included NRT upon request. Research done on single call programs show abstinence rates of about 15 percent compared to control rates of 7 percent (Zhu 2000). The goal of preventive activities such as the Quitline is to reduce disease and death related to tobacco use, which is the leading cause of chronic diseases such as cancer, heart disease and stroke. These key factors drive the need for the preventive Quitline services:

- State funded Quitline services provide support for tobacco cessation to people without insurance and help reduce smoking prevalence among low income and low-educated adults. Quitline services provided by private and Medicaid insurance do the same for people with adequate coverage, particularly when insurance plans provide cessation services that people are aware of services such as the statewide Quitline.
- A national advertising campaign was aired by the CDC in spring of 2013 encouraged people to call their local Quitlines and this campaign is still generating unique calls. CDC has indicated its intention to do cessation campaigns every year, including 2014, so DOH expects call volumes that exceed available CDC grant funding.
- Health care providers are more likely to counsel their patients to quit using tobacco if there is a resource like the Quitline to support patient referrals.
- No-smoking policies are some of the most effective interventions to reduce smoking rates. DOH's most effective tool to reduce smoking rates at this time is to encourage adoption of no-smoking policies. This includes policies by businesses and housing providers. Businesses and apartment owners are more

likely to create no-smoking policies when they know that people affected by those policies can get help quitting tobacco.

The department expects that 2,896 people without insurance benefits for tobacco cessation will have access to Quitline services, increasing their chance of successfully quitting tobacco use. This supports the current Results Washington goal to reduce smoking prevalence among adults and youth.

Performance Measure Detail

Activity: A002 Chronic Disease Prevention

Is this DP essential to implement a strategy identified in the agency's strategic plan?

This decision package supports to the following performance measure in the 2012-16 Department of Health Strategic Plan as a significant community based prevention program with high efficacy:

Goal 3: Everyone in Washington has improved access to safe, quality, and affordable health care.
Objective 2: Public health and prevention practices are incorporated into the healthcare delivery system.
Strategy 1: Integrate high impact quality clinical preventive services into the health care delivery system.

Does this decision package provide essential support to one of the Governor's priorities?

Yes. This decision package supports Results Washington Goal 4 -- Healthy and Safe Communities:

Measure 1.2.Y-c: Decrease percentage of 10th graders who report smoking cigarettes in past 30 days from 10% in 2012 to 9% by 2017.

Measure 1.2.A-b: Decrease percentage of adults who smoke cigarettes from 17% in 2011 to 15% by 2017.

Measure 1.2A.b.1: Decrease percentage of persons who smoke cigarettes among those with low education (high school or less) from 26% in 2011 to 23% by 2016, and pregnant women from 9% to 8% by 2016.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government process?

Yes. Tobacco usage is the leading cause of chronic disease in Washington State. This request contributes to the health of Washingtonians, which rates high in terms of statewide priorities. People who quit smoking have immediate health benefits. People who use Quitlines more than double their chances of quitting, (Zhu 2000) resulting in better health outcomes and healthcare savings for the state.

Currently the state pays more than \$650 million per year in smoking related healthcare costs. It is estimated that a savings of \$12,730 or more is achieved for every person who quits smoking. This savings results in a combined lifetime savings of \$10,693,200 – when we apply Washington's quit rate experience of 29 percent to the 2,896 people without insurance benefits for tobacco cessation quit smoking. This scenario represents a lifetime return on investment of \$16 saved for every \$1 spent. This is an example of how preventative activities, such as the Quitline, leverage public resources by yielding high returns on investment and creating opportunities for cost avoidance.

Expenditure data is based on research reported by the Campaign for Tobacco Free Kids – the savings amount has been updated to reflect 2012 dollars. Source:

<http://www.tobaccofreekids.org/research/factsheets/pdf/0327.pdf>

What are the other important connections or impacts related to this proposal?

Access to Quitline and cessation services is a priority for several health and chronic disease prevention related stakeholders. Those stakeholders include the American Lung Association, American Heart Association, American Cancer Society, Campaign for Tobacco Free Kids and the Centers for Disease Control and Prevention Office on Smoking and Health. This stakeholder list also includes federal agencies that provide grant funding for preventive efforts – and in turn expect the state to leverage federal resources with state dollars and programs.

Everyone in Washington State pays for smoking-related illnesses. Total annual costs from a 2007 study conducted by the Center for Health Research, Kaiser Permanente Northwest:

- \$1.9 Billion for total personal healthcare
- \$1.8 Billion in productivity losses
- \$651 Million is spent every year for public-funded healthcare to treat tobacco-related illnesses.
- Every Washington household pays an estimated \$628 per year for smoking-related healthcare – even if nobody in that household smokes. This keeps healthcare costs high – and impacts affordability (premiums, deductibles and co-pays) and access.

What alternatives were explored by the agency and why was this alternative chosen?

General Fund-State support for a state Quitline is being requested because dedicated funding for smoking cessation is not currently available. Dedicated funding has been eliminated over the past several years. There may be better ways to fund and deliver Quitline services through health care reform, but practical alternatives will take time to develop and require consultation with stakeholders. It is possible that a system could be arranged to have hospitals and insurance plans provide pooled coverage for Quitline services for people who carry their coverage (insured) and people who are uninsured. No such model is currently in existence based on DOH's August 2013 consultation with the CDC Office of Smoking and Health and the North American Quitline Consortium. Consultations have also been held with Oregon's Quitline administrators to determine potential options for covering those costs.

Another alternative includes using a portion of the \$14.8 million due to the state as a result of the recent 2013 Master Settlement Agreement (MSA) arbitration decision impacting funds in the MSA Disputed Payment Account related to calendar year 2003.

Implementing an alternative funding method will require working with the Office of the Insurance Commissioner, the Health Care Authority and the Health Benefits Exchange. This will require DOH leadership as well as a willingness from hospitals, insurance plans or other potential funders to engage in consultation. Some form of a comprehensive alternative aimed at securing dedicated funding, or required health plan /hospital pooled funding for cessation services may require rule-making or legislation.

What are the consequences of not funding this package?

- Not funding the Quitline and cessation services will result in fewer people quitting tobacco usage, higher healthcare costs for the state, and increased non-smoker exposure to second-hand smoke.
- Meeting the Results Washington objectives of reducing the number of adult smokers will be difficult within segments of the population that are financially unable to enroll in healthcare coverage.
- Chronic disease caused by tobacco usage has a significant impact on public and private healthcare expenditures. Tobacco related healthcare costs include hospitalizations and long term care. Paying for these costs diverts tax dollars from other essential functions of state and local government.

- Limited access to cessation service may also reduce the number of private apartment owners and businesses that establish smoke-free policies that are relied upon to effectively implement those policies.

What is the relationship, if any, to the state capital budget?

N/A

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

Prospective alternatives aimed at securing state dedicated funding, or requiring health plans/hospital participation in a funding pool for cessation services will likely require rule-making, legislation and stakeholder work.

Expenditure and revenue calculations and assumptions

Revenue:

N/A

Expenditures:

In FY 2013, the state funding provided Quitline services to 4,137 people who did not have private insurance or Medicaid. With the expansion of Medicaid and implementation of the healthcare exchange, DOH anticipates a 30 percent reduction in the number of uninsured people accessing Quitline services. This estimate is based on data from the *Congressional Budget Office's May 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage*. This leaves 2,896 uninsured people accessing the Quitline in FY 2015 – this estimate does not account for additional demand built up over the course of FY 2014. Based on FY 2013 usage data, 29 percent of the uninsured callers only called once – and 71 percent of the callers requested multiple calls. A single call to the Quitline costs \$71 per person, whereas the multiple call program costs \$151 per person for up to 5 calls. In FY 2013, about 89 percent of people using the Quitline requested nicotine replacement therapy (NRT) in the form of gum or patches. Gum costs \$70 for a 4 week supply – and patches costs \$59 for a four week supply. The Quitline is expected to receive 1,500 calls from people with insurance that does not use the state's Quitline vendor. The state's Quitline vendor will collect rudimentary demographic information on these callers then transfer them to cessation services covered by their health plan. Each transfer will be charged to the state at the rate of \$20 per transfer. In the future, a more appropriate cost allocation model will be developed to relieve the state from the burden of paying for warm transfers to health plans. Warm transfers currently alleviate the barrier to access that would otherwise reduce the number of people who successfully quit. The Quitline vendor is required to record and report Quitline usage data. Estimated cost for Quitline service during FY 2015 is \$545,000.

Based on prior experience managing the Quitline program, DOH needs to maintain its existing Cessation Coordinator (Health Services Consultant 3) to coordinate the implementation of healthcare reform and access to cessation services. Prior to the eliminate of General Fund-State Quitline support, funding for the Cessation Coordinator position was split between General Fund-State and CDC grant funding. Access to CDC grant funding beyond FY 2014 is unknown, so full General Fund-State support is being requested to maintain the position.

Total Costs for FY 2015 are \$663,000.

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

DOH anticipates gradual reductions in need for state funded Quitline services as more people are enrolled in coverage through the health benefits exchange and expanded Medicaid. Assuming General Fund-State funding is provided in FY 2015, access to state supported Quitline services will enable DOH to collect call data to estimate funding needs for 2015-17, as the initial wave of ACA related enrollment occurs.

For federal grants: Does this request require maintenance of effort or state match?

N/A

For all other funding: Does this request fulfill a federal grant's maintenance of effort or match requirement?

None.

Object Detail		FY 2014	FY 2015	Total
A	Salaries and Wages		77,000	77,000
B	Employee Benefits		24,000	24,000
C	Personal Service Contracts		545,000	545,000
E	Goods and Services		15,000	15,000
G	Travel		0	0
J	Capital Outlays		0	0
T	Intra-Agency Reimbursements		2,000	2,000
Total Objects			663,000	663,000

OFM

303 - Department of Health
Capital Project Request

2013-16 Biennium

Version: FS 2014 Supplemental

Report Number: CBS002

Date Run: 10/2/2013 2:39PM

Project Number: 30000306

Project Title: Install new Electrical & Gas Service

Description

Starting Fiscal Year: 2014
Project Class: Program
Agency Priority: 1

Project Summary

The project is another phase in the separation of Public Health Lab and Fircrest Campus utilities as outlined in the Public Health Lab 20 year Master Plan. This project will construct a new electrical utility substation drop from Seattle City Light and establish an independent gas line with Puget Sound Energy

Project Description

This Project will construct a separate medium voltage electrical service to the Washington State Department of Health Public Health Laboratories (PHL).

The campus was originally built in 1942 as a navy hospital. Eventually it became a Developmentally Disabled facility for DSHS. The PHL was built in 1985 when the Dept. of Health was part of DSHS. In 1988 the Dept. of Health was created as a separate agency with its headquarters in Tumwater and the PHL remaining located on the existing Fircrest Campus. The PHL continued to receive all of its utilities from the Fircrest Campus after the agencies split.

The Public Health Labs (PHL) is located on DOH property at the south end of the Fircrest campus and receives all of its utilities from the DSHS Fircrest Campus. The electrical service is provided by Seattle City Light (SCL) and is fed from the North Utility Substation located in the northwest corner of the Fircrest campus. The existing 1500 KVA service transformer provides all the electrical power to the PHL via a medium voltage 4.16 KV service feeder approximately 1,800 feet in length. This service feeder was installed by DSHS in 1970 and is now approximately 18 years past its 25 year life expectancy. The North Utility Substation was installed pre-1980 and is also reaching its expected life expectancy. DSHS has no intent to replace the PHL service feeder as it only serves the public health lab. If this medium voltage feeder or substation were to fail, the PHL would be forced to run the facility solely on generator power until the feeder or substation could be repaired. This would seriously hamper the ability of the PHL to carry out its mission.

The Public Health Laboratory's 20-year master plan calls for the electrical service to be replaced with a new service drop from NE 150th St, which is the south boundary of the PHL property. This drop would then connect to new feeder lines on the north side of the PHL property that were installed as part of the PHL Addition project completed during the 11-13 biennium.

Replacing the electrical service now would ensure the continued, reliable operation of the Public Health Laboratories to meet the needs of the growing state population.

There will be no operational impact until the 2015-17 budget cycle. Operational impacts will be normal maintenance costs. The project will be funded through the State Building Construction Account. No federal or other sources of funding are available for this project.

This project will create 8.0 jobs in FY 14 and 4.1 jobs in FY 15.

Location

City: Shoreline

County: King

Legislative District: 032

Project Type

Infrastructure (Major Projects)

New Facility: No

How does this fit in master plan

This project is part of our site infrastructure upgrades. The existing medium voltage line is ten years beyond its normal life cycle and needs to be replaced.

Funding

Expenditures

2013-15 Fiscal Period

OFM

303 - Department of Health
Capital Project Request

2013-15 Biennium

Version: FS 2014 Supplemental

Report Number: CBS002

Date Run: 10/2/2013 2:39PM

Project Number: 3000305
Project Title: Install new Electrical & Gas Service

Funding						
Acct Code	Account Title	Estimated Total	Prior Biennium	Current Biennium	New Reappropr	New Approps
057-1	State Bldg Constr-State	1,139,000				1,139,000
	Total	1,139,000	0	0	0	1,139,000
Future Fiscal Periods						
		2015-17	2017-19	2019-21	2021-23	
057-1	State Bldg Constr-State					
	Total	0	0	0	0	

Schedule and Statistics		
	Start Date	End Date
Pre-design		
Design	7/1/2013	4/1/2014
Construction	5/1/2014	6/1/2015
	Total	
Gross Square Feet:	1	
Usable Square Feet:	1	
Efficiency:	100.0%	
Escalated MACC Cost per Sq. Ft.:	802,023	
Construction Type:	Other Schedule A Projects	
Is this a remodel?	No	
A/E Fee Class:	A	
A/E Fee Percentage:	11.84%	

Cost Summary		
	Escalated Cost	% of Project
Acquisition Costs Total	0	0.0%
Consultant Services		
Pre-Schematic Design Services	0	0.0%
Construction Documents	64,548	5.7%
Extra Services	20,880	1.8%
Other Services	29,870	2.6%
Design Services Contingency	11,786	1.0%
Consultant Services Total	127,084	11.2%
Maximum Allowable Construction Cost(MACC)	802,023	
Site work	728,042	63.9%
Related Project Costs	0	0.0%

303 - Department of Health
 Capital Project Request

2013-16 Biennium

Version: FS 2014 Supplemental

Report Number: CBS002

Date Run: 10/2/2013 2:39PM

Project Number: 30000305

Project Title: Install new Electrical & Gas Service

Cost Summary

	<u>Escalated Cost</u>	<u>% of Project</u>
Construction Contracts		
Facility Construction	73,981	6.5%
GCCM Risk Contingency	0	0.0%
GCCM or Design Build Costs	0	0.0%
Construction Contingencies	122,068	10.7%
Non Taxable Items	0	0.0%
Sales Tax	87,788	7.7%
Construction Contracts Total	<u>1,011,879</u>	<u>88.8%</u>
Equipment		
Equipment	0	0.0%
Non Taxable Items	0	0.0%
Sales Tax	0	0.0%
Equipment Total	<u>0</u>	<u>0.0%</u>
Art Work Total	0	0.0%
Other Costs Total	0	0.0%
Project Management Total	0	0.0%
Grand Total Escalated Costs	<u><u>1,138,963</u></u>	
Rounded Grand Total Escalated Costs	1,139,000	

Operating Impacts

No Operating Impact

Narrative

There should be no additional operational impacts as the PHL is replacing an existing system. There should be less maintenance time spent on the new system.

OFM

Capital Project Request

2013-15 Biennium

<u>Parameter</u>	<u>Entered As</u>	<u>Interpreted As</u>
Biennium	2013-15	2013-15
Agency	303	303
Version	FS-A	FS-A
Project Classification	*	All Project Classifications
Capital Project Number	30000305	30000305
Sort Order	Project Priority	Priority
Include Page Numbers	Y	Yes
For Word or Excel	N	N
User Group	Agency Budget	Agency Budget
User Id	*	All User Ids